

Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name : MD TANIM RAFIQU
ISLAM
Card No : I040-029-122437818-01
Policy Holder : MD TANIM RAFIQU
ISLAM
Payer Name : UNION INSURANCE
COMPANY
TPA : E CARE - Blue Network
Validity : 18-03-2025 To 01-01-
2026
Gender : Male
Date Of Birth : 10-Mar-2003
Patient's Tel No : 0506390236

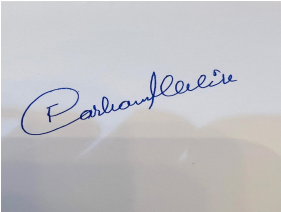
Service Date :13-Apr-2025 Network : Green
Health :CITICARE MEDICAL CENTER LLC
Provider :
Doctor's Name :Dr.Farhan Iyas

Direct Access SP - YES

Co-Insurance :

CONSULTATION	LAB/RADIOLOGY	PHYSIO	PHARMACY	IP	MATERNITY	DENTAL
10% max	NIL	NIL	NIL LIMIT	NIL	10%	NA

Remarks :

☐ Acute	☐ Pre-existing and chronic	☐ Maternity
Chief Complaints : itching dryness redness over both upper surface of feet since 2 days Duration :		
Vitals: Temp : 37 Bp :110 Pulse :70 Resp :18		
Clinical Findings:		
Diagnosis: L23.9 - Allergic contact dermatitis, unspecified cause,L20.84 - Intrinsic (allergic) eczema, Date of Onset : 13/44/2025		
Requested Investigations: 0005-111805-1021, CHLOROHISTOL 10MG,96372, THER/PROPH/DIAG INJ SC/IM,85027, BLOOD COUNT COMPLETE AUTOMATED,9, Consultation GP Estimated Cost :		
Prescriptions: 0320-148701-1171 - (LORATADINE : 10 MG) TABLETS,5252-027801-0151 - (BETAMETHASONE (AS DIPROPIONATE) : 0.5MG / G) (MICONAZOLE NITRATE : 20 MG/G) CREAM, Estimated Cost :		
MEDICAL PRACTITIONER DECLARATION : I declare that I am the patient's medical practitioner and that the particulars given are to the best of my knowledge true and correct.		
PATIENT'S DECLARATION : I hereby authorize any Healthcare provider, Insurer, Employer or other organization to release any information regarding my medical condition & history for purpose of determining insurance benefits.		
Dr's Name : Dr.Farhan Iyas	Stamp : Dr .Frahan Ilyas Malik Physician-General Practitioner DHA-06441782-001 CITICARE MEDICAL CENTER DUBAI U.A.E	Patient 's signature{Parent : if minor}  Date : 13-Apr-2025
Signature : 	Date : 13-Apr-2025	