Administrative **MEDICAL CLAIM FORM** **Claim Ref:**

Patient Name	**: VIGNESHKUMAR LAKSHMANAN LAKSHMANAN**
Card No	**: I005-029-119704083-01**
Policy Holder	**: VIGNESHKUMAR LAKSHMANAN LAKSHMANAN**
Payer Name	**: DUBAI INSURANCE COMPANY**
TPA	**: E CARE - Blue Network**
Validity	**: 08-08-2024** To **07-08-2025**
Gender	**: Male**
Date Of Birth	**: 23-Jan-1994**
Patient's Tel No	**: 0523864580**

Service Date **:07-May-2025** **Network** : Green

Health Provider **:CITICARE MEDICAL CENTER LLC** **Direct Access SP - YES**

Doctor's Name **:AISHA**

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 : pt came with head injury. while entering in the van oe its small scratch and mild swelling . no swelling **Duration:**

Vitals:

Clinical Findings:

Diagnosis: R52 - Pain, unspecified, **Date of Onset** : 07/07/2025

Estimated Cost :

Requested Investigations: 9, Consultation GP

Estimated Cost :

Prescriptions:

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 : AISHA **Stamp :**

Dr. Aisha Umer
Physician- General Practitioner
DHA- 40131439-002
CITICARE MEDICAL CENTER
DUBAI - U.A.E

Patient 's signature{Parent if minor} : **Date :** 07-May-2025

Signature : **Date** : 07-May-2025