Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	**: Shahbaz . Showkat**
Card No	**: I005-029-118413978-02**
Policy Holder	**: Shahbaz . Showkat**
Payer Name	**: DUBAI INSURANCE COMPANY**
TPA	**: E CARE - Blue Network**
Validity	**: 25-06-2024** To **24-06-2025**
Gender	**: Male**
Date Of Birth	**: 10-Oct-1990**
Patient's Tel No	**: 0504092666**

Service Date **:08-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 left hand index finger knife cut wound that happened half hour back ,when he was cutting vegetables . its Lshape cut aroud 1.5 cm in length profuse bleeding ,sensory and motor movements are intact 4 sutures given CAME FOR DREESIING pt came with left hand index finger knife cut wound that happened half hour back ,when he was cutting vegetables . its Lshape cut aroud 1.5 cm in length profuse bleeding ,sensory and motor movements are intact 4 sutures given pt came with left hand index finger knife cut wound that happened half hour back ,when he was cutting vegetables . its Lshape cut aroud 1.5 cm in length profuse bleeding ,sensory and motor movements are intact 4 sutures given **Duration:**

Vitals: Temp : 36.7 Bp :140 Pulse :86 Resp :0

Clinical Findings:

Diagnosis: S61.211S - Laceration w/o fb of l idx fngr w/o damage to nail, sequela,S61.201A - Unsp open wound of l idx fngr w/o damage to nail, init,T81.31XA - Disruption of external operation (surgical) wound, NEC, init,R52 - Pain, unspecified, **Date of Onset** **:**08/12/2025

Requested Investigations: 51.01, Non-surgical cleansing with surgical dressing 16 sq inches / 100 sq centimeters or less,9, Consultation GP,96365, THER/PROPH/DIAG IV INF INIT,96372, THER/PROPH/DIAG INJ SC/IM,0005-149902-1021, CLOFEN ,93000, ELECTROCARDIOGRAM COMPLETE **Estimated Cost** **:**

Prescriptions: **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.

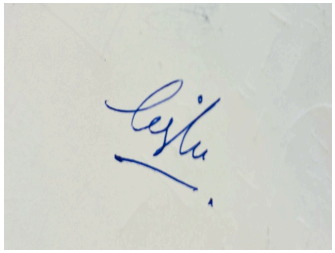
PATIENT'S DECLARATION :

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 **:** 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 :** 08-May-2025

Signature :  **Date** **:** 08-May-2025