Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	: **MOHAMMED SHAHAB UDDIN ABDUL MABUD**	**Service Date**	**:02-Jun-2025** **Network** : Green
Card No	: **I040-029-119600415-01**	**Health Provider**	**:CITICARE MEDICAL CENTER LLC** **Direct Access SP - YES**
Policy Holder	: **MOHAMMED SHAHAB UDDIN ABDUL MABUD**	**Doctor's Name**	**:AISHA**
Payer Name	: **UNION INSURANCE COMPANY**	**Co-Insurance**	:
TPA	: **E CARE - Blue Network**		
Validity	: **02-01-2025** To **01-01-2026**	**Remarks**	:
Gender	: **Male**		
Date Of Birth	: **08-Mar-1985**		
Patient's Tel No	: **0581676397**		

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

☐ **Acute** ☐ **Pre-existing and chronic** ☐ **Maternity**

Chief Complaints : PC: ALLERGIC FUNGAL INFECTION AT THE LEFT SIDE OF FACE FOR LONG TIME **Duration:**
OE IRREGULAR ERYTHMATOUS MARGIN IS PRESENT

Vitals: Temp : 36.4 Bp :124 Pulse :97 Resp :0

Clinical Findings:

Diagnosis: L23.89 - Allergic contact dermatitis due to other agents,L23.4 - Allergic contact dermatitis due to dyes,B36.9 - Superficial mycosis, unspecified, **Date of Onset** :02/58/2025

Estimated Cost :

Requested Investigations: 9, Consultation GP

Prescriptions: 0159-140504-0151 - (CLOTRIMAZOLE : 1%) CREAM,0005-119803-1171 - (PREDNISOLONE : 20 MG) TABLETS,0195-123701-0391 - (CETIRIZINE HCL : 10 MG) FILM COATED TABLETS,7048-140201-0061 - (FLUCONAZOLE : 150 MG) CAPSULES, **Estimated Cost** :

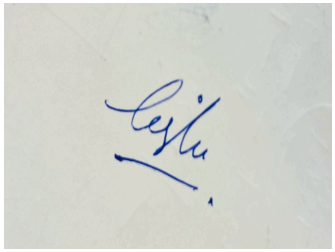
MEDICAL PRACTITIONER DECLARATION :

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.

Dr's Name : AISHA

Stamp :

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

Signature : 

Date : 02-Jun-2025

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.

Patient 's signature{Parent : if minor} 

Date : 02-Jun-2025