Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	**: RENE JR MACABULOS FLORENTINO**
Card No	**: P5676102B**
Policy Holder	**: RENE JR MACABULOS FLORENTINO**
Payer Name	**: HAYAH INSURANCE COMPANY P.J.S.C**
TPA	**: E CARE - Green Network**
Validity	**: 27-05-2025 To 26-05-2026**
Gender	**: Male**
Date Of Birth	**: 14-Apr-1979**
Patient's Tel No	**: 0504148557**

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

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

Doctor's Name :Dr.Farhan Iyas

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 : PC : FOLLOW UP FOR LABS HYPERURECEMIA LOW VITAMIN D DERRANGED LIPID PROFILE **Duration:**

Vitals: Temp : 36.6 Bp :130 Pulse :78 Resp :18

Clinical Findings:

Diagnosis: R82.993 - Hyperuricosuria,M1A.3320 - Chronic gout due to renal impairment, left wrist, w/o tophus,E55.9 - Vitamin D deficiency, unspecified,E78.5 - Hyperlipidemia, unspecified, **Date of Onset :**07/33/2025

Requested Investigations: Pa001, GENARAL WELLNESS PACKEGE,9, Consultation GP **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 : 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 :** 07-Jun-2025

Signature : **Date** : 07-Jun-2025