Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	: **MOHAMMED SHAHAB UDDIN ABDUL MABUD**	**Service Date**	**:13-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**	**:DR Amaizah**
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 : slin rash on cheek eryrhmatous which cuase itching and burning started **Duration:** 01/06/25 took meds not improved o/e : raised erythmatous plaques on cheek

Vitals: Temp : 36.8 Bp :128 Pulse :100 Resp :18

Clinical Findings:

Diagnosis: R21 - Rash and other nonspecific skin eruption,B35.0 - Tinea barbae and tinea capitis,R73.03 - Prediabetes, **Date of Onset** :13/37/2025

Requested Investigations: 82947, GLUCOSE QUANTITATIVE BLOOD XCPT REAGENT STRIP,0005-111805-1021, CHLOROHISTOL 10MG,0248-122107-1021, DEXAMETHASONE SODIUM PHOSPHATE,96372, THER/PROPH/DIAG INJ SC/IM,9, Consultation GP **Estimated Cost** :

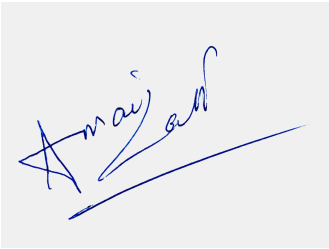
Prescriptions: 0195-123701-0391 - (CETIRIZINE HCL : 10 MG) FILM COATED TABLETS,7048-140201-0061 - (FLUCONAZOLE : 150 MG) CAPSULES,0027-109206-0151 - (TERBINAFINE (AS HCL) : 1%) CREAM, **Estimated Cost** :

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.

Dr's Name : DR Amaizah **Stamp :**

Dr. Amaizah Ishtiaq
General Practitioner
DHA: 98486553-001
CITICARE MEDICAL CENTER
DUBAI - U.A.E

Signature :  **Date** : 13-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 :** 13-Jun-2025