

Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name

: MOHAMMED SHAHAB UDDIN ABDUL MABUD

Card No

: I040-029-119600415-01

Policy Holder

: MOHAMMED SHAHAB UDDIN ABDUL MABUD

Payer Name

: UNION INSURANCE COMPANY

TPA

: E CARE - Blue Network

Validity

: 02-01-2025 To 01-01-2026

Gender

: Male

Date Of Birth

: 08-Mar-1985

Patient's Tel No

: 0581676397

Service Date

:14-Jun-2025

Health Provider

:CITICARE MEDICAL CENTER LLC

Doctor's Name

:DR Amaizah

Co-Insurance

Network

: Green

Direct Access SP - YES

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 : slin rash on cheek eryrhmatus which cuase itching and burning started 01/06/25 took meds not improved o/e : raised erythmatous plaques on cheek

Vitals:

Clinical Findings:

Diagnosis:

R21 - Rash and other nonspecific skin eruption,B35.0 - Tinea barbae and tinea capitis,R73.03 - Prediabetes,E11.65 - Type 2 diabetes mellitus with hyperglycemia,

Date of Onset

:14/08/2025

Requested Investigations:

85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT

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.

Dr's Name

: DR Amaizah

Signature

Date

: 14-Jun-2025

Stamp

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

: Jun-2025