Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	: **JEET BAHADUR KHATRI**	**Service Date**	:**22-Jun-2025** **Network** : Green
Card No	: **I040-029-120209240-01**	**Health Provider**	:**CITICARE MEDICAL CENTER LLC** **Direct Access SP - YES**
Policy Holder	: **JEET BAHADUR KHATRI**	**Doctor's Name**	:**Dr.Farhan Iyas**
Payer Name	: **UNION INSURANCE COMPANY**	**Co-Insurance**	:
TPA	: **E CARE - Blue Network**	**Remarks**	:
Validity	: **02-01-2025** To **01-01-2026**		
Gender	: **Male**		
Date Of Birth	: **02-Aug-1980**		
Patient's Tel No	: **0504753940**		

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 : chief complaint: came with cold and pain in the back. previous history: hypertension 16/12/2024 allergy: no allergy with any medication. **Duration:**

Vitals: Temp : 36.8 Bp :152 Pulse :90 Resp :18

Clinical Findings:

Diagnosis: M54.5 - Low back pain,R50.9 - Fever, unspecified, **Date of Onset** : 22/16/2025

Requested Investigations: 0005-149902-1021, CLOFEN ,96372, THER/PROPH/DIAG INJ SC/IM,9, Consultation GP **Estimated Cost** :

Prescriptions: 0097-142201-0391 - (DICLOFENAC POTASSIUM : 50 MG) FILM COATED TABLETS,0006-106601-0394 - (PARACETAMOL : 500 MG) FILM COATED TABLETS, **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.

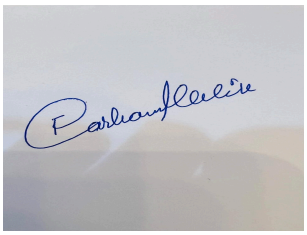
PATIENT'S DECLARATION :

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** : 22-Jun-2025

Signature :  **Date** : 22-Jun-2025