Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	: NABIN KUMAR DAS	**Service Date**	:15-Jul-2025
Card No	: I040-029-119613171-01	**Health Provider**	:CITICARE MEDICAL CENTER LLC
Policy Holder	: NABIN KUMAR DAS	**Doctor's Name**	:AISHA
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	: 03-May-1999		
Patient's Tel No	: 0567429609		

Network : Green

Direct Access SP - YES

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 : **Duration :**

Vitals: Temp : 36 Bp :120 Pulse :86 Resp :18

Clinical Findings:

Diagnosis: S61.211D - Laceration w/o fb of l idx fngr w/o damage to nail, subs,S61.201A - Unsp open wound of l idx fngr w/o damage to nail, init, **Date of Onset** :15/09/2025

Estimated Cost :

Requested Investigations: 29720, REPAIR SPICA BODY CAST/JACKET,9, Consultation GP

Estimated Cost :

Prescriptions:

MEDICAL PRACTITIONER DECLARATION :

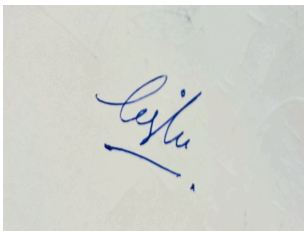
I declare that I am the patient's medical practitioner and that the particulars given are to the best of my knowledge true and correct.

Dr's Name : AISHA

Stamp :

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

Signature :



Date : 15-Jul-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 : 15-Jul-2025