## Administrative

## MEDICAL CLAIM FORM

## Claim Ref:

| | | | |
|---|---|---|---|
| **Patient Name** | : **Sachin Pandurang Vinherkar** | **Service Date** | :**17-Jul-2025** **Network** : Green |
| **Card No** | : **I040-029-113718954-01** | **Health Provider** | :**CITICARE MEDICAL CENTER LLC** **Direct Access SP - YES** |
| **Policy Holder** | : **Sachin Pandurang Vinherkar** | **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** | : **07-Jan-1984** | | |
| **Patient's Tel No** | : **0503667303** | | |

| 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 : allergic reaction **Duration :**

**Vitals:**Temp : 36.8 Bp :130 Pulse :80 Resp :18

**Clinical Findings:**

**Diagnosis:** R21 - Rash and other nonspecific skin eruption, **Date of Onset** : 17/42/2025

**Requested Investigations:** 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.

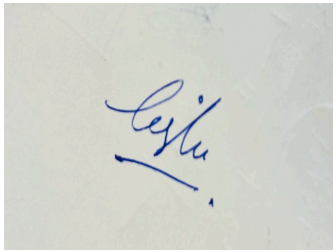
**PATIENT'S DECLARATION :**

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** : AISHA **Stamp :**

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

**Patient 's signature{Parent if minor}** : **Date** : 17-Jul-2025

**Signature :**  **Date** : 17-Jul-2025