Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	: **HARVIN HIMPIL CAMACHO**	**Service Date**	:**25-Jul-2025**
Card No	: **01-Jan-2026**	**Health Provider**	:**CITICARE MEDICAL CENTER LLC**
Policy Holder	: **HARVIN HIMPIL CAMACHO**	**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	: **02-Nov-1992**		
Patient's Tel No	: **0567094078**		

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 : pc : cirular ash on inner thigh **Duration :**

Vitals: Temp : 36.8 Bp :140 Pulse :88 Resp :18

Clinical Findings:

Diagnosis: B35.6 - Tinea cruris,R21 - Rash and other nonspecific skin eruption, **Date of Onset** :25/59/2025

Estimated Cost :

Requested Investigations: 9, Consultation GP

Prescriptions: 0006-126003-0652 - (FLUTICASONE : 0.05MG/G) OINTMENT,5252-672101-0152 - (MICONAZOLE NITRATE : 20 MG/G) (MOMETASONE FUROATE : 1 MG/G) CREAM,

Estimated Cost :

MEDICAL PRACTITIONER DECLARATION :

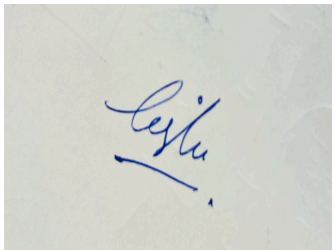
I declare that I am the patient's medical practitioner and that the particulars given are to the best of my knowledge true and correct.

Dr's Name : AISHA

Stamp :

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

Signature :



Date : 25-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 : 25-Jul-2025