Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	**: RAJAMANI CHELLAYAN**	**Service Date**	**:16-Aug-2025** **Network** : Green
Card No	**: I040-029-113383351-01**	**Health Provider**	**:CITICARE MEDICAL CENTER LLC** **Direct Access SP - YES**
Policy Holder	**: RAJAMANI CHELLAYAN**	**Doctor's Name**	**:Dr.Farhan Iyas**
Payer Name	**: UNION INSURANCE COMPANY**	**Co-Insurance :**	
TPA	**: ECARE-EBP EBP Enhanced CLASIC**	**Remarks**	**:**
Validity	**: 13-01-2025** To **12-01-2026**		
Gender	**: Male**		
Date Of Birth	**: 06-Jun-1966**		
Patient's Tel No	**: 0556895440**		

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 : came for unstitching of suture 556895440 PATIENT CONTACT NUMBER **Duration :**

Vitals: Temp : 36.9 Bp :120 Pulse :84 Resp :18

Clinical Findings:

Diagnosis: S01.81XA - Laceration w/o foreign body of oth part of head, init encntr,Z48.02 - Encounter for removal of sutures, **Date of Onset** :16/54/2025

Estimated Cost :

Requested Investigations: 15850, REMOVAL OF SUTURES

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.

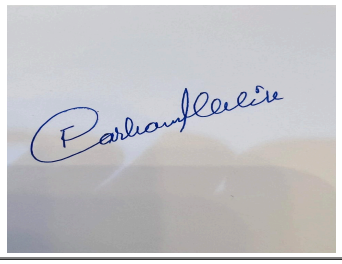
PATIENT'S DECLARATION :

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 :** 16-Aug-2025

Signature :  **Date** : 16-Aug-2025