

Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name : Mansoor Ali Yameen Ali

Card No : I040-029-113719090-01

Policy Holder : Mansoor Ali Yameen Ali

Payer Name : UNION INSURANCE COMPANY

TPA : E CARE - Blue Network

Validity : 02-01-2024 To 01-01-2025

Gender : Male

Date Of Birth : 25-Sep-1985

Patient's Tel No : 0502245460

Service Date :15-Oct-2024

Health Provider :CITICARE MEDICAL CENTER LLC

Doctor's Name :AHSAN HUSSAIN

Co-Insurance :

CONSULTATION	LAB/RADIOLOGY	PHYSIO	PHARMACY	IP	MATERNITY	DENTAL
10% max	NIL	NIL	NIL LIMIT	NIL	10%	NA

Remarks :

Network : Green

Direct Access SP - YES

☐ Acute

☐ Pre-existing and chronic

☐ Maternity

Chief Complaints : PC: REFILL MEDICATION PAIN IN RIGHT HEEL

Duration :

Vitals:Temp : 36.7 Bp :142 Pulse :91 Resp :18

Clinical Findings:

Diagnosis: I10 - Essential (primary) hypertension,R52 - Pain, unspecified,M79.18 - Myalgia, other site,M62.830 - Muscle spasm of back,

Date of Onset :15/48/2024

Estimated Cost :

Requested Investigations: 9, Consultation GP

Prescriptions: 0278-107902-0391 - (IBUPROFEN : 400 MG) FILM COATED TABLETS,1217-373201-2401 - (TOLPERISONE : 150 MG) SUGAR COATED TABLETS,0252-155401-0391 - (LOSARTAN POTASSIUM : 50 MG) FILM COATED TABLETS,

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 : AHSAN HUSSAIN

Stamp :

Dr. Ahsan Hussain

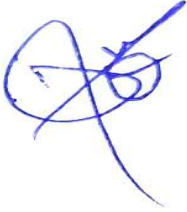
General Practitioner

DHA No: 87543658-001

CITICARE MEDICAL CENTER LLC

DUBAI - U.A.E,

Signature :



Date : 15-Oct-2024

Patient 's signature{Parent : if minor}



Date : Oct-2024

https://irhamc.visionsoftwares.ae/mr_ecare_claim_print.aspx?appld=53772&patId=26657

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