Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	**: GANGA KERUNG**
Card No	**: I040-029-113718932-01**
Policy Holder	**: GANGA KERUNG**
Payer Name	**: UNION INSURANCE COMPANY**
TPA	**: E CARE - Blue Network**
Validity	**: 02-01-2024** To **01-01-2025**
Gender	**: Male**
Date Of Birth	**: 08-Oct-1981**
Patient's Tel No	**: 0503621186**

Service Date :03-Dec-2024 **Network** : Green

Health Provider :CITICARE MEDICAL CENTER LLC **Direct Access SP - YES**

Doctor's Name :Humaira

Co-Insurance :

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

Remarks :

☐ **Acute** ☐ **Pre-existing and chronic** ☐ **Maternity**

Chief Complaints : co came here to show the labs vit d is 9 oe chest is clear no added sounds restless **Duration:**

Vitals: Temp : 36 Bp :130 Pulse :86 Resp :18

Clinical Findings:

Diagnosis: E55.9 - Vitamin D deficiency, unspecified, **Date of Onset** : 03/29/2024

Requested Investigations: 9, Consultation GP **Estimated Cost** :

Prescriptions: 0444-640412-0971 - (VITAMIN D3 (CHOLECALCIFEROL : 50000 IU SOFT GELATIN CAPSULES, **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.

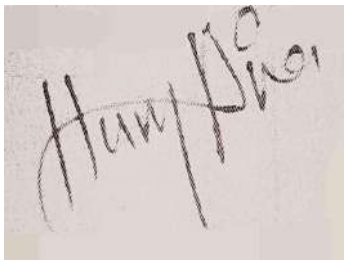
PATIENT'S DECLARATION :

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 : Humaira **Stamp :**

Dr. Humaira Mumtaz
General Practitioner
DHA No: 54155530-002
CITICARE MEDICAL CENTER LLC
DUBAI - U.A.E.

Patient 's signature{Parent if minor} : **Date** : 03-Dec-2024

Signature :  **Date** : 03-Dec-2024