

# UCAF 2

To be Completed & verified by Reception / Nurse :

Provider Name : Elite Hospital  
 Insurance Co. : 250144 BHARATKUMAR SELVARAJ#25000567  
 TPA Name 006 GLOBE MED  
 Patient File No. : 667561 Dept : DENTAL  
 Date of Birth : 02-07-1998 Age : 27Y  
 Date of Visit: 14-03-2026  Single  Married Plan Type :  
 New Visit  Follow Up / Refill  Walk-in  Referral

Print / fill in clear letters or Emboss Card

Beneficiary  
 Bhara Thkumar Selvaraj  
 ID Card 38361750 Sex male Age 27Y  
 Policy Holder Policy No. 25000567  
 Expiry Date 14-04-2026 Class 3HARATKUMAF  
 Approval

To be Completed by Attending PHYSICIAN Please tick (✓ )

Inpatient  Outpatient \ Emergency Case?  Yes  No Emergency Care Level : 1 ( ) 2 ( ) 3 ( )  
 BP: 120/80 Pulse: 80 bpm Temp: 36 C Weight : 66 Kg Height : 166 cm R.R: \_\_\_\_\_ Duration of illness: 1 Days  
 Chief Complaint & Main Symptoms  
 dental pain

Significant Signs:

dental caries

Other Conditions pulpitis in the tooth 38 , it has a severe root curvation and needs a maxillofacial specialist to do the surgery , which is not available in our hospital

Diagnosis Dental caries, unspecified

Principal Code: K02.9 2nd Code: \_\_\_\_\_ 3rd Code: \_\_\_\_\_ 4th Code: \_\_\_\_\_

Please tick (✓) where appropriate:

Chronic  Congenital  RTA  Work Related  Vaccination  Check-Up  
 Psychiatric  Infertility  Pregnancy Indicate LMP : \_\_\_\_\_

Suggestive line(s) of management: Kindly, enumerate the recommended investigations, and/or procedure for Outpatient approvals only:

Code *	Description/Service	Type	Quantity	Cost *
DNT0001	DENTAL CONSULTATION SEPC		1	60.00
<b>Total</b>			1	60.00

Providers Approval / Coding staff must review / code the recommended service(s) and allocate cost and complete the following: Completed / Coded By..... Signature ..... Date .....

Code *	Medication Name ( Generic Name )	Type	Quantity
<b>Total</b>			

- Is Case Management Form ( CMF 1.0 ) included  Yes  No

Please specify possible line of management when applicable

Estimated length of Stay ..... days Expected Date of Admission .... / .... / .....

I hereby certify that ALL information mentioned are correct & that the medical services shown on this form were medically indicated & necessary

for the management of this case.

Physician Name Signature : Khaled Adel Rajab

Date : / /

**Dr. Khalid Rajab**  
(Orthodontist)  
101

I hereby certify that all statements & information provided concerning patient identification & the present illness or injury are TRUE

أقر بأن المعلومات المذكورة أعلاه و المتعلقة بهوية المريض و المعلومات المنطقه بالمرض أو الإصابة الحالية صحيحة

Name & Relationship (if guardian) Signature Date: / /

\* Provider's Approval / Coding Staff must review / code the recommended service(s) & allocate cost and complete the following:

Total Cost: SR..... As estimated / Package Deal  
 Completed / Coded by: ..... Signature ..... Date ..... / .....

For Insurance Company Use Only  Approved  Not Approved Approval No.: ..... Approval Validity: .....

Comments : include approved days services if different from the requested)

Insurance Officer. \_\_\_\_\_ Singnature \_\_\_\_\_ Date: / /

مستشفى النخبة  
**Elite Hospital**

