Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	**: Yin Yin Aye**
Card No	**: I040-029-117580473-01**
Policy Holder	**: Yin Yin Aye**
Payer Name	**: UNION INSURANCE COMPANY**
TPA	**: E CARE - Blue Network**
Validity	**: 02-01-2024** To **01-01-2025**
Gender	**: Female**
Date Of Birth	**: 01-Jun-1977**
Patient's Tel No	**: 0555402967**

Service Date :06-Aug-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 itching near the eyes swelling around the eyes has a history of eating sea food after that she develop these things oe chest is clear skin rash stable **Duration:**

Vitals: Temp : 37 Bp :118 Pulse :74 Resp :18

Clinical Findings:

Diagnosis: L29.9 - Pruritus, unspecified,R21 - Rash and other nonspecific skin eruption, **Date of Onset** :06/42/2024

Requested Investigations: 0005-111805-1021, CHLOROHISTOL 10MG-(CHLORPHENIRAMINE MALEATE : 10 MG/ML) SOLUTION FOR INJECTION,96372, THER/PROPH/DIAG INJ SC/IM,9, Consultation GP **Estimated Cost** :

Prescriptions: 0006-131401-0151 - BETAMETHASONE,0195-123701-0391 - (CETIRIZINE HCL : 10 MG) FILM COATED TABLETS, **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.

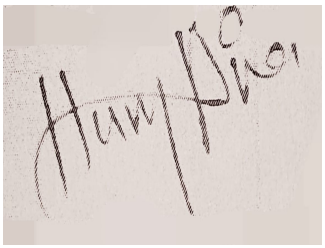
PATIENT'S DECLARATION :

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 :** 06-Aug-2024

Signature :  **Date** : 06-Aug-2024