Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	: **CHAMARA MADUSHANKA HOLIPITIGE**	**Service Date**	:**24-Sep-2024**
Card No	: **I040-029-118549984-01**	**Health Provider**	:**CITICARE MEDICAL CENTER LLC**
Policy Holder	: **CHAMARA MADUSHANKA HOLIPITIGE**	**Doctor's Name**	:**AHSAN HUSSAIN**
Payer Name	: **UNION INSURANCE COMPANY**	**Co-Insurance**	:
TPA	: **E CARE - Blue Network**		
Validity	: **02-01-2024** To **01-01-2025**	**Remarks**	:
Gender	: **Male**		
Date Of Birth	: **26-Jul-1991**		
Patient's Tel No	: **00000000000**		

Network : Green

Direct Access SI

CONSULTATION	LAB/ RADIOLOGY	PHYSIO	PHARMACY	IP	MATEF
10% max	NIL	NIL	NIL LIMIT	NIL	10%

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

Chief Complaints : PC: FEVER FLU BODY PAIN SORETHROAT EPIGASTRIC PAIN **Duration :**

Vitals: Temp : 37.4 Bp :118 Pulse :108 Resp :18

Clinical Findings:

Diagnosis: J06.9 - Acute upper respiratory infection, unspecified,J00 - Acute nasopharyngitis [common cold],K21.9 - Gastro-esophageal reflux disease without esophagitis,M62.830 - Muscle spasm of back,R05 - Cough,M54.5 - Low back pain, **Date of Onset**

Requested Investigations: 0005-107704-0802, TRIAXONE I.V.-(CEFTRIAXONE : 1 G) POWDER FOR INJECTION,2190-106618-1001, PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE,0005-174202-0781, RISEK 40MG,0188-135906-2441, PULMICORT-(BUDESONIDE : 0.5 MG/ML) SUSPENSION FOR NEBULIZATION,94640, AIRWAY INHALATION TREATMENT,96365, THER/PROPH/DIAG IV INF INIT,96372, THER/PROPH/DIAG INJ SC/IM,85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,86140, C REACTIVE PROTEIN,9, Consultation GP **Estimated Cost :**

Prescriptions: 0027-265802-1161 - (BUTAMIRATE DIHYDROGEN CITRATE : 0.15% W/V) SYRUP,0252-185801-0391 - (DIPHENHYDRAMINE : 25 MG) (PARACETAMOL : 500 MG) (PSEUDOEPHEDRINE : 30 MG) FILM COATED TABLETS,0139-116206-1171 - (CLAVULANIC ACID : 125 MG) (AMOXICILLIN : 875 MG) TABLETS,0195-123701-0391 - CETIRIZINE HCL, **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.

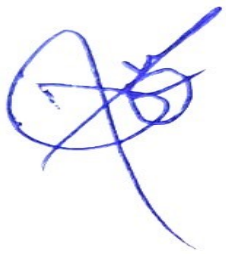
Dr's Name : AHSAN HUSSAIN **Stamp :**

PATIENT'S DECLARATION :

I hereby authorize any Healthcar or other organization to release a medical condition & history for p insurance benefits.

Patient 's signature{Parent : if minor}

Dr. Ahsan Hussain
General Practitioner
DHA No: 87543658-001
CITICARE MEDICAL CENTER LLC
DUBAI - U.A.E.

Signature : 

Date : 24-Sep-2024