Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	: **Sujith Dias Walawe Gamage**	**Service Date**	:**01-Nov-2024** **Network** : Green
Card No	: **I040-029-114504431-01**	**Health Provider**	:**CITICARE MEDICAL CENTER LLC** **Direct Access SP - YES**
Policy Holder	: **Sujith Dias Walawe Gamage**	**Doctor's Name**	:**Humaira**
Payer Name	: **UNION INSURANCE COMPANY**	**Co-Insurance**	:
TPA	: **E CARE - Green Network**	**Remarks**	:
Validity	: **01-10-2024** To **30-09-2025**		
Gender	: **Male**		
Date Of Birth	: **04-Mar-1992**		
Patient's Tel No	: **0564998297**		

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

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

Chief Complaints : CO WATERY EYE BURNING IN THE EYES 30th oct 2024 oe watery eyes with congestion restless **Duration:**

Vitals: Temp : 37.5 Bp :112 Pulse :88 Resp :18

Clinical Findings:

Diagnosis: H10.33 - Unspecified acute conjunctivitis, bilateral,R52 - Pain, unspecified,R50.9 - Fever, unspecified, **Date of Onset :**01/35/2024

Estimated Cost :

Requested Investigations: 9, Consultation GP

Prescriptions: 0005-107001-0051 - (CAFFEINE : 65 MG) (PARACETAMOL : 500 MG) CAPLETS,0085-125903-0372 - (MOXIFLOXACIN (AS HCL) : 0.5%) EYE DROPS,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 :** 01-Nov-2024

Signature : **Date** : 01-Nov-2024