Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	**: NISAL GURUNG**
Card No	**: I040-029-121353783-01**
Policy Holder	**: NISAL GURUNG**
Payer Name	**: UNION INSURANCE COMPANY**
TPA	**: E CARE - Blue Network**
Validity	**: 11-09-2024** To **01-01-2025**
Gender	**: Male**
Date Of Birth	**: 28-Feb-1989**
Patient's Tel No	**: 0509869230**

Service Date **:18-Nov-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 watery discharge 13th nov. 2024 oe chest is clear no added sounds restless **Duration:**

Vitals: Temp : 36 Bp :120 Pulse :86 Resp :18

Clinical Findings:

Diagnosis: H04.203 - Unspecified epiphora, bilateral,J30.9 - Allergic rhinitis, unspecified, **Date of Onset** **:**18/59/2024

Estimated Cost **:**

Requested Investigations: 9, Consultation GP

Prescriptions: 0031-123312-0662 - (SODIUM HYALURONATE : 2 MG/ML) OPHTHALMIC SOLUTION,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.

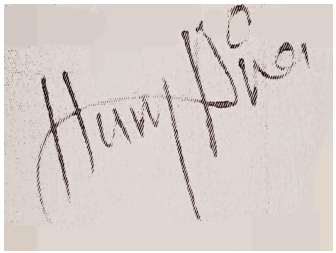
PATIENT'S DECLARATION :

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 :** 18-Nov-2024

Signature :  **Date** **:** 18-Nov-2024