Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	**: SMARIKA THAPA HARI KUMAR THAPA CHHETRI**	**Service Date**	**:24-Jan-2025**	**Network**	**: Green**
Card No	**: I040-029-118791094-01**	**Health Provider**	**:CITICARE MEDICAL CENTER LLC**		**Direct Access SP - YES**
Policy Holder	**: SMARIKA THAPA HARI KUMAR THAPA CHHETRI**	**Doctor's Name**	**:Humaira**		
Payer Name	**: UNION INSURANCE COMPANY**	**Co-Insurance**	**:**		
TPA	**: E CARE - Blue Network**	**Remarks**	**:**		
Validity	**: 02-01-2025** To **01-01-2026**				
Gender	**: Female**				
Date Of Birth	**: 19-Oct-1992**				
Patient's Tel No	**: 0552049819**				

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 : **Duration :**

Vitals: Temp : 37.1 Bp :120 Pulse :86 Resp :22

Clinical Findings:

Diagnosis: J06.9 - Acute upper respiratory infection, unspecified,J30.9 - Allergic rhinitis, unspecified,R05 - Cough,R50.9 - Fever, unspecified,K29.00 - Acute gastritis without bleeding, **Date of Onset :** 24/01/2025

Requested Investigations: 9.01, Follow Up Consultation GP **Estimated Cost :**

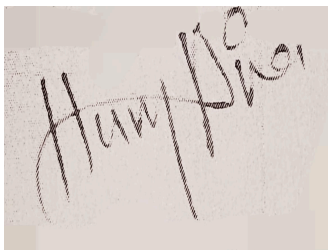
Prescriptions: **Estimated Cost :**

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 : Humaira **Stamp :**

Dr. Humaira Mumtaz
General Practitioner
DHA No: 54155530-002
CITICARE MEDICAL CENTER LLC
DUBAI - U.A.E.

Signature :  **Date :** 24-Jan-2025

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.

Patient 's signature{Parent : if minor} **Date :** 24-Jan-2025