Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	: GOKUL KRISHNA THACHARIL SUBRAMANIAN	**Service Date**	:26-Jan-2025	**Network**	: Green
Card No	: I040-029-120817373-01	**Health Provider**	:CITICARE MEDICAL CENTER LLC		**Direct Access SP - YES**
Policy Holder	: GOKUL KRISHNA THACHARIL SUBRAMANIAN	**Doctor's Name**	:DR Amaizah		
Payer Name	: UNION INSURANCE COMPANY	**Co-Insurance**	:		
TPA	: E CARE - Blue Network	**Remarks**	:		
Validity	: 01-01-2026 To 01-01-2026				
Gender	: Male				
Date Of Birth	: 05-Jul-2001				
Patient's Tel No	: 971563093585				

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 : pc : sorethroat, cough , runny nose, bodypain and fever for 3 days bp is elevated not allergic to any med hx of recurrent sinusitis o/e hyperemia of pharynx chest is congested **Duration:**

Vitals: Temp : 36.6 Bp :150 Pulse :86 Resp :18

Clinical Findings:

Diagnosis: J02.9 - Acute pharyngitis, unspecified,J06.9 - Acute upper respiratory infection, unspecified,R50.9 - Fever, unspecified,R05 - Cough,J01.41 - Acute recurrent pansinusitis, **Date of Onset** :26/05/2025

Estimated Cost :

Requested Investigations: 9, Consultation GP

Prescriptions: 0195-123701-0391 - (CETIRIZINE HCL : 10 MG FILM COATED TABLETS,0005-107001-0052 - (CAFFEINE : 65 MG) (PARACETAMOL : 500 MG) CAPLETS,0397-116207-0391 - (AMOXICILLIN : 500 MG (CLAVULANIC ACID : 125 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 : DR Amaizah **Stamp :**

Dr. Amaizah Ishtiaq
General Practitioner
DHA: 98486553-001
CITICARE MEDICAL CENTER
DUBAI - U.A.E

Patient 's signature{Parent if minor} : **Date** : 26-Jan-2025

Signature : **Date** : 26-Jan-2025