Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	: **SMARIKA THAPA HARI KUMAR THAPA CHHETRI**	**Service Date:**	**11-Feb-2025**
Card No	: **I040-029-118791094-01**	**Health Provider**	**:CITICARE MEDICAL CENTER LLC**
Policy Holder	: **SMARIKA THAPA HARI KUMAR THAPA CHHETRI**	**Doctor's Name**	**:DR Amaizah**
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**		

Network : Green

Direct Access SP - YES

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 : SWELLING AND REDNESS OF LOWER EYELID OF RT EYE STARTED YESTERDAY MELASMA. AND HYPOPIGMENTTYED AREAS ON FACE NO HX OF FOOD OR DRUG ALLERGY O/E : SWOLLEN , RED EYE LID **Duration:**

Vitals: Temp : 36.6 Bp :120 Pulse :74 Resp :22

Clinical Findings:

Diagnosis: R21 - Rash and other nonspecific skin eruption,R50.9 - Fever, unspecified,L03.211 - Cellulitis of face, **Date of Onset :**11/25/2025

Requested Investigations: 85027, BLOOD COUNT COMPLETE AUTOMATED,86140, C REACTIVE PROTEIN,0195-107704-0802, CEFTRIAXONE-TABUK IM,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE-(DEXAMETHASONE : 4 MG/ML) SOLUTION FOR INJECTION,96365, THER/PROPH/DIAG IV INF INIT,96372, THER/PROPH/DIAG INJ SC/IM,9, Consultation GP **Estimated Cost :**

Estimated Cost :

Prescriptions:

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** : 11-Feb-2025

Signature : **Date** : 11-Feb-2025