Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	: **Surendra Kumar Chaudhri**	**Service Date**	:**12-Feb-2025** **Network** : Green
Card No	: **I040-029-117537322-01**	**Health Provider**	:**CITICARE MEDICAL CENTER LLC** **Direct Access SP - YES**
Policy Holder	: **Surendra Kumar Chaudhri**	**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	: **Male**		
Date Of Birth	: **18-Apr-1988**		
Patient's Tel No	: **0522963916**		

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 PUSS FILLED LESION ON LEFT GROING AREA NO OTHER MED CONDITIONS BP IS ELEVTAED O/E : RED SWOLEN TENDER BUPM ON LEFT GROIN **Duration:**

Vitals: Temp : 36.6 Bp :160 Pulse :78 Resp :18

Clinical Findings:

Diagnosis: R21 - Rash and other nonspecific skin eruption,L03.818 - Cellulitis of other sites,R50.9 - Fever, unspecified, **Date of Onset** :12/55/2025

Requested Investigations: 85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,86140, C REACTIVE PROTEIN,0195-107704-0801, CEFTRIAXONE-TABUK IV,0005-149902-1021, CLOFEN -(DICLOFENAC SODIUM : 75 MG/3ML) SOLUTION FOR INJECTION,96372, THER/PROPH/DIAG INJ SC/IM,9, Consultation GP,96365, THER/PROPH/DIAG IV INF INIT **Estimated Cost** :

Prescriptions: 0027-149903-0391 - (DICLOFENAC SODIUM : 100 MG) FILM COATED TABLETS,0031-187502-0151 - (BETAMETHASONE : 0.10%) (FUSIDIC ACID : 2%) CREAM,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 :** 12-Feb-2025

Signature : **Date** : 12-Feb-2025