Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	: **Surendra Kumar Chaudhri**	**Service Date**	:**13-Feb-2025**
Card No	: **I040-029-117537322-01**	**Health Provider**	:**CITICARE MEDICAL CENTER LLC**
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	: **0562997905**		

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 : FOLLOW UP FOR LAB REPORTS HIGH LEVELS OF CHOLESTEROL AND TGS SWELLING AND TENDERNESS AT GROIN IMROVED **Duration:**

Vitals: Temp : 36.8 Bp :150 Pulse :78 Resp :18

Clinical Findings:

Diagnosis: E78.2 - Mixed hyperlipidemia,I10 - Essential (primary) hypertension,R21 - Rash and other nonspecific skin eruption,R50.9 - Fever, unspecified, **Date of Onset** :13/56/2025

Requested Investigations: 0195-107704-0801, CEFTRIAXONE-TABUK IV,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE-(DEXAMETHASONE : 4 MG/ML) SOLUTION FOR INJECTION,96372, THER/PROPH/DIAG INJ SC/IM,96365, THER/PROPH/DIAG IV INF INIT,9.01, Follow Up Consultation GP **Estimated Cost** :

Prescriptions: 6763-379201-1171 - (AMLODIPINE (AS BESYLATE : 5 MG TABLETS,0880-155602-0391 - (ROSUVASTATIN (AS CALCIUM) : 10 MG) FILM COATED TABLETS, **Estimated Cost** :

MEDICAL PRACTITIONER DECLARATION :

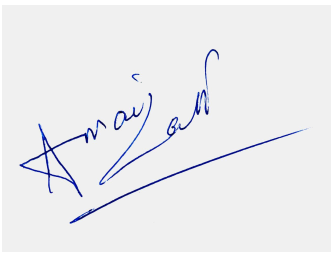
I declare that I am the patient's medical practitioner and that the particulars given are to the best of my knowledge true and correct.

Dr's Name : DR Amaizah

Stamp :

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

Signature :



Date : 13-Feb-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 : 13-Feb-2025