Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	**: SHALIKA MADUWANTHI KULAWANSHA KARUNA PELIGE**
Card No	**: I040-029-119668661-01**
Policy Holder	**: SHALIKA MADUWANTHI KULAWANSHA KARUNA PELIGE**
Payer Name	**: UNION INSURANCE COMPANY**
TPA	**: E CARE - Blue Network**
Validity	**: 02-01-2025** To **01-01-2026**
Gender	**: Female**
Date Of Birth	**: 20-Feb-1996**
Patient's Tel No	**: 0561360824**

Service Date **:16-Feb-2025** **Network** : Green

Health Provider **:CITICARE MEDICAL CENTER LLC** **Direct Access SP - YES**

Doctor's Name **:Humaira**

Co-Insurance :

CONSULTATION	LAB/RADIOLOGY	PHYSIO	PHARMACY	IP	MATERNITY	DENTAL
10% max	NIL	NIL	NIL LIMIT	NIL	10%	NA

Remarks :

☐ **Acute** ☐ **Pre-existing and chronic** ☐ **Maternity**

Chief Complaints : patient came with the complain of fever sore throat and body ache for one day . chest is clear .no wheezing . **Duration:**

Vitals: Temp : 36.6 Bp :114 Pulse :88 Resp :18

Clinical Findings:

Diagnosis: J02.9 - Acute pharyngitis, unspecified,R50.9 - Fever, unspecified,R05 - Cough,J30.9 - Allergic rhinitis, unspecified, **Date of Onset** :16/45/2025

Requested Investigations: 0102-111908-1001, SODIUM CHLORIDE B.P.,2190-106618-1001, PARAFUSIV,0005-149902-1021, CLOFEN ,96372, THER/PROPH/DIAG INJ SC/IM,85004, BLOOD COUNT AUTOMATED DIFFERENTIAL WBC COUNT,86140, C REACTIVE PROTEIN,9, Consultation GP,96360, HYDRATION IV INFUSION INIT **Estimated Cost** :

Prescriptions: 0097-127402-0391 - (AZITHROMYCIN : 250 MG) FILM COATED TABLETS,0195-123701-0391 - (CETIRIZINE HCL : 10 MG) FILM COATED TABLETS,0005-116702-2481 - (DIPHENHYDRAMINE : 12.5 MG/5ML) SYRUP (SUGAR FREE),0788-106705-1171 - (CHLORPHENIRAMINE MALEATE : 2 MG) (PARACETAMOL : 500 MG) (PSEUDOEPHEDRINE : 30 MG) 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.

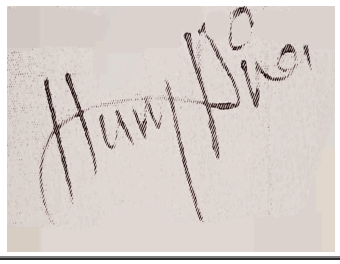
PATIENT'S DECLARATION :

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 : Humaira **Stamp :**

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

Patient 's signature{Parent if minor} : **Date** : 16-Feb-2025

Signature :  **Date** : 16-Feb-2025