Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	**: RAJAN JOSEPH JOSEPH RAJAPPAN**
Card No	**: I040-029-117773737-01**
Policy Holder	**: RAJAN JOSEPH JOSEPH RAJAPPAN**
Payer Name	**: UNION INSURANCE COMPANY**
TPA	**: E CARE - Blue Network**
Validity	**: 02-01-2025** To **01-01-2026**
Gender	**: Male**
Date Of Birth	**: 25-May-1977**
Patient's Tel No	**: 0588074897**

Service Date **:01-Mar-2025** **Network** : Green

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

Doctor's Name **:DR Amaizah**

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 : pc : severe redness , rash and eruption on elbows and back of neck 26/02/25 after exposure to hair dye associtaed with itching and thickening of skin started 26/02/25 o/e :erythmatous rash on elbows with skin eruptions **Duration:**

Vitals: Temp : 36.8 Bp :120 Pulse :74 Resp :22

Clinical Findings:

Diagnosis: R21 - Rash and other nonspecific skin eruption,R52 - Pain, unspecified, **Date of Onset** :01/46/2025

Requested Investigations: 0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE-(DEXAMETHASONE : 4 MG/ML) SOLUTION FOR INJECTION,0005-111805-1021, CHLOROHISTOL 10MG-(CHLORPHENIRAMINE MALEATE : 10 MG/ML) SOLUTION FOR INJECTION,85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,86140, C REACTIVE PROTEIN,96372, THER/PROPH/DIAG INJ SC/IM,82785, GAMMAGLOBULIN IGE,0005-149902-1021, CLOFEN -(DICLOFENAC SODIUM : 75 MG/3ML) SOLUTION FOR INJECTION,9, Consultation GP **Estimated Cost** :

Prescriptions: 0031-187502-0151 - (BETAMETHASONE : 0.10%) (FUSIDIC ACID : 2%) CREAM,0006-126002-0152 - (FLUTICASONE : 0.5 MG/G CREAM,0005-119803-1172 - (PREDNISOLONE : 20 MG) TABLETS,0195-123701-0391 - (CETIRIZINE HCL : 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.

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

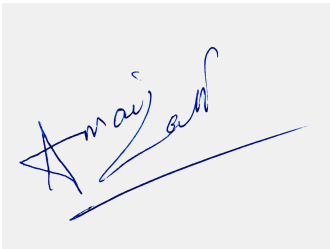
Stamp :

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

Patient 's signature{Parent if minor} :

Date : 01-Mar-2025

Signature :



Date : 01-Mar-2025