Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	: **ANISHA ANIL KATTIKKARAN**	**Service Date**	**:06-Mar-2025** **Network** : Green
Card No	: **I040-029-121542378-01**	**Health Provider**	**:CITICARE MEDICAL CENTER LLC** **Direct Access SP - YES**
Policy Holder	: **ANISHA ANIL KATTIKKARAN**	**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	: **29-Sep-1999**		
Patient's Tel No	: **0553685056**		

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 : sore throat , sneezing , started 03/03/25 associatef with low garde fever **Duration:**
hx of food osya bean allergy and eczema previously

Vitals: Temp : 36.8 Bp :120 Pulse :86 Resp :18

Clinical Findings:

Diagnosis: J30.9 - Allergic rhinitis, unspecified,J01.41 - Acute recurrent pansinusitis,R09.81 - Nasal congestion,R05 - Cough,J06.9 - Acute upper respiratory infection, unspecified, **Date of Onset** :06/27/2025

Requested Investigations: 85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,86140, C REACTIVE PROTEIN,86005, ALLERGEN SPECIFIC IGE QUAL MULTIALLERGEN SCREEN,94640, AIRWAY INHALATION TREATMENT,0005-111805-1021, CHLOROHISTOL 10MG-(CHLORPHENIRAMINE MALEATE : 10 MG/ML) SOLUTION FOR INJECTION,96372, THER/PROPH/DIAG INJ SC/IM,9, Consultation GP **Estimated Cost** :

Prescriptions: 0252-389902-1172 - (LORATADINE : 5 MG (PSEUDOEPHEDRINE SULPHATE : 120 MG TABLETS, **Estimated Cost** :

MEDICAL PRACTITIONER DECLARATION :

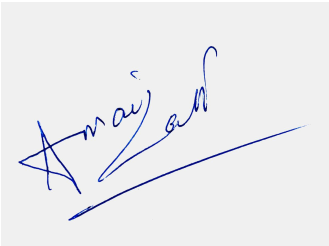
I declare that I am the patient's medical practitioner and that the particulars given are to the best of my knowledge true and correct.

Dr's Name : DR Amaizah

Stamp :

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

Signature :



Date : 06-Mar-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 : 06-Mar-2025