Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	**: LAKAI MITRA JATINDRA MITRA MITRA**
Card No	**: I040-029-113719086-01**
Policy Holder	**: LAKAI MITRA JATINDRA MITRA MITRA**
Payer Name	**: UNION INSURANCE COMPANY**
TPA	**: E CARE - Blue Network**
Validity	**: 02-01-2025** To **01-01-2026**
Gender	**: Male**
Date Of Birth	**: 05-Mar-1982**
Patient's Tel No	**: 508842935**

Service Date :07-Mar-2025 **Network** : Green

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

Doctor's Name **:AISHA**

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 HAVE ITCHING IN THE HEAD NO ANY RED PATCHES DRY SKIN **Duration :**

Vitals: Temp : 36.8 Bp :110 Pulse :76 Resp :18

Clinical Findings:

Diagnosis: L23.89 - Allergic contact dermatitis due to other agents,R21 - Rash and other nonspecific skin eruption,L50.8 - Other urticaria,K29.00 - Acute gastritis without bleeding,R19.7 - Diarrhea, unspecified,R14.3 - Flatulence,

Date of Onset :07/34/2025

Requested Investigations: 0005-111805-1021, CHLOROHISTOL INJECTION,96372, THER/PROPH/DIAG INJ SC/IM,9, Consultation GP

Estimated Cost :

Prescriptions: 0159-140504-2611 - (CLOTRIMAZOLE : 1%) TOPICAL SOLUTION,0006-149803-0651 - (CLOBETASOL PROPIONATE : 0.5 MG/G OINTMENT,0270-189301-0081 - (ALUMINIUM HYDROXIDE : N/A (SODIUM BICARBONATE : N/A (ALGINIC ACID : N/A (MAGNESIUM TRISILICATE : N/A CHEWABLE TABLETS,6445-533801-1561 - (ESOMEPRAZOLE (AS MAGNESIUM : 20 MG DELAYED RELEASE CAPSULES,1654-525701-1091 - (CHARCOAL, ACTIVATED : 250 MG) (SIMETHICONE : 80 MG) SUGAR-COATED TAB,

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 : AISHA

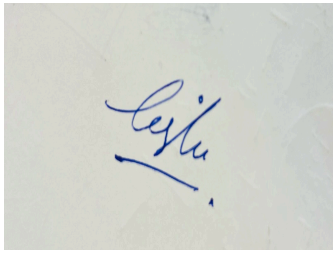
Stamp :

Dr. Aisha Umer
Physician- General Practitioner
DHA- 40131439-002
CITICARE MEDICAL CENTER
DUBAI - U.A.E

Patient 's signature{Parent if minor} :

Date : 07-Mar-2025

Signature :



Date : 07-Mar-2025