## 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** **:08-Mar-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 :** sore throat dry cough body ache flu at night o/e chest is clear **Duration :**

**Vitals:**Temp : 36.4 Bp :109 Pulse :94 Resp :0

**Clinical Findings:**

**Diagnosis:** J02.9 - Acute pharyngitis, unspecified,R05 - Cough,R52 - Pain, unspecified, **Date of Onset** :08/55/2025

**Requested Investigations:** 85004, BLOOD COUNT AUTOMATED DIFFERENTIAL WBC COUNT,86140, C REACTIVE PROTEIN,9, Consultation GP **Estimated Cost** :

**Prescriptions:** 4884-622202-1171 - (SERRAPEPTASE : 10 MG) TABLETS,0006-106601-0392 - (PARACETAMOL : 500 MG) FILM COATED TABLETS,4235-446701-1161 - (SODIUM CITRATE : 57 MG/5ML (AMMONIUM CHLORIDE : 131.5 MG/5 ML (MENTHOL : 1.1 MG/5 ML (DIPHENHYDRAMINE HCL : 13.5 MG/5ML SYRUP,0320-148701-1171 - (LORATADINE : 10 MG TABLETS,0097-127405-0391 - (AZITHROMYCIN : 500 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.

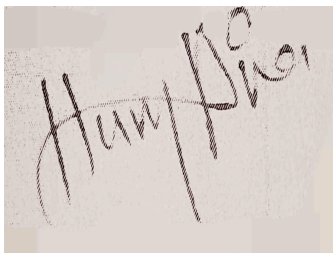
**PATIENT'S DECLARATION :**

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** : 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 :** 08-Mar-2025

**Signature :**  **Date** : 08-Mar-2025