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 **:10-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 : CRP is 11.8 came 2 days back with sore throat,dry cough,body ache,flu. **Duration :**

Vitals: Temp : 36 Bp :115 Pulse :84 Resp :0

Clinical Findings:

Diagnosis: J06.9 - Acute upper respiratory infection, unspecified,R05 - Cough, **Date of Onset** **:**10/01/2025

Requested Investigations: 0195-107704-0801, CEFTRIAXONE-TABUK IV,0102-152902-1001, LACTATED RINGERS INJECTION USP,0248-122107-1021, DEXAMETHASONE SODIUM PHOSPHATE,96365, THER/PROPH/DIAG IV INF INIT,9.01, Follow Up Consultation GP,96374, THER/PROPH/DIAG INJ IV PUSH **Estimated Cost** **:**

Estimated Cost :

Prescriptions:

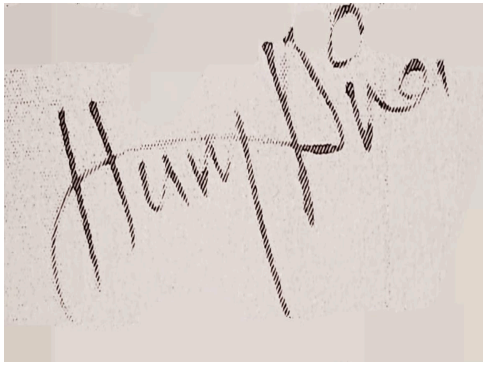
MEDICAL PRACTITIONER DECLARATION :

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 : Humaira

Stamp :

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

Signature : 

Date : 10-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 : 10-Mar-2025