Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	: **MATHAN MANIKANDA KUMAR MANIKANDA KUMAR**	**Service Date**	**:02-Apr-2025** **Network** : Green
Card No	: **I005-029-118327143-01**	**Health Provider**	**:CITICARE MEDICAL CENTER LLC** **Direct Access SP - YES**
Policy Holder	: **MATHAN MANIKANDA KUMAR MANIKANDA KUMAR**	**Doctor's Name**	**:DR Amaizah**
Payer Name	: **DUBAI INSURANCE COMPANY**	**Co-Insurance**	:
TPA	: **E CARE - Blue Network**	**Remarks**	:
Validity	: **08-08-2024** To **07-08-2025**		
Gender	: **Male**		
Date Of Birth	: **25-Jul-1995**		
Patient's Tel No	: **0525756326**		

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 , COUGH WITH MUCOUS , YELLOW IN COLOR HAVE LOW GRADE FEVER STARTED 26/03/25 PC: LOOK LETHAGIC DEHYDRATED HYPEREMIC PHARYNX, PC : **Duration:**

Vitals: Temp : 36.9 Bp :170 Pulse :78 Resp :18

Clinical Findings:

Diagnosis: J02.9 - Acute pharyngitis, unspecified,R05 - Cough,R50.9 - Fever, unspecified, **Date of Onset** :02/01/2025

Requested Investigations: 0005-111805-1021, CHLOROHISTOL 10MG-(CHLORPHENIRAMINE MALEATE : 10 MG/ML) SOLUTION FOR INJECTION,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE-(DEXAMETHASONE : 4 MG/ML) SOLUTION FOR INJECTION,85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,86140, C REACTIVE PROTEIN,0195-107704-0802, CEFTRIAXONE-TABUK IM,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE,0005-111805-1021, CHLOROHISTOL 10MG,96372, THER/PROPH/DIAG INJ SC/IM,94640, AIRWAY INHALATION TREATMENT,96365, THER/PROPH/DIAG IV INF INIT,96374, THER/PROPH/DIAG INJ IV PUSH,9, Consultation GP **Estimated Cost :**

Prescriptions: 6705-602505-3801 - (HYDROXYPROPYLMETHYLCELLULOSE : 150 MG/ 30ML) SPRAY SOLUTION,0397-116207-0391 - (AMOXICILLIN : 500 MG) (CLAVULANIC ACID : 125 MG) FILM COATED 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 :** 02-Apr-2025

Signature : **Date** : 02-Apr-2025