

Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name : MATHAN MANIKANDA
: KUMAR MANIKANDA
KUMAR
Card No : I005-029-118327143-01
Policy Holder : MATHAN MANIKANDA
: KUMAR MANIKANDA
KUMAR
Payer Name : DUBAI INSURANCE
: COMPANY
TPA : E CARE - Blue Network
Validity : 08-08-2024 To 07-08-2025
Gender : Male
Date Of Birth : 25-Jul-1995
Patient's Tel No : 0525756326

Service Date : 02-Apr-2025
Network : Green
Health Provider : CITICARE MEDICAL CENTER LLC
Direct Access SP - YES
Doctor's Name : DR Amaizah

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
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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 :
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

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,

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.

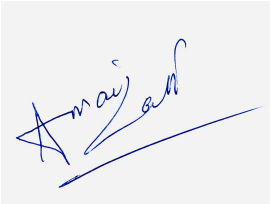
PATIENT'S DECLARATION :
I hereby authorize any Healthcare provider, Insurer, Employer or other organization to release any information regarding my medical condition & history for purpose of determining insurance benefits.

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}

02-Apr-2025

Signature : 

Date : 02-Apr-2025