Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	**: NISAL GURUNG**
Card No	**: I040-029-121353783-01**
Policy Holder	**: NISAL GURUNG**
Payer Name	**: UNION INSURANCE COMPANY**
TPA	**: E CARE - Blue Network**
Validity	**: 02-01-2025** To **01-01-2026**
Gender	**: Male**
Date Of Birth	**: 28-Feb-1989**
Patient's Tel No	**: 0509869230**

Service Date **:04-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**

Chief Complaints : SORE THROAT , BODYPAIN , HEADACHE , LETHARGY AND COUGH WHICH IS DRY STRATED 03/04/25 O/E : LOOK LETHARGIC FEBRILE TONSILLS ARE SWOLEN , RED WITH PUS POINTS HYPEREMIC PHARYN X CHEST WHEEZING **Duration:**

Vitals: Temp : 37.3 Bp :116 Pulse :86 Resp :18

Clinical Findings:

Diagnosis: J03.90 - Acute tonsillitis, unspecified,R50.9 - Fever, unspecified,R05 - Cough,R06.2 - Wheezing, **Date of Onset** :04/43/2025

Requested Investigations: 0195-107704-0802, CEFTRIAXONE-TABUK IM,2190-106618-1001, PARAFUSIV,0005-111805-1021, CHLOROHISTOL 10MG,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE,96365, THER/PROPH/DIAG IV INF INIT,94640, AIRWAY INHALATION TREATMENT,0006-402803-2071, VENTOLIN NEBULES,96372, THER/PROPH/DIAG INJ SC/IM,85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,86140, C REACTIVE PROTEIN,9, Consultation GP **Estimated Cost** :

Prescriptions: 0027-142201-0831 - (DICLOFENAC POTASSIUM : 50 MG) POWDER FOR SOLUTION,0006-106601-0393 - (PARACETAMOL : 500 MG) FILM COATED TABLETS,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

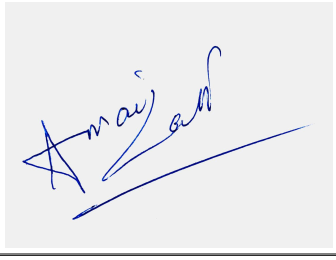
Stamp :

Dr. Amaizah Ishtiaq
General Practitioner
DHA: 98486553-001
CITICARE MEDICAL CENTER
DUBAI - U.A.E

Patient 's signature{Parent if minor} :

Date : 04-Apr-2025

Signature :



Date : 04-Apr-2025