Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	: **NISAL GURUNG**	**Service Date**	:**05-Apr-2025** **Network** : Green
Card No	: **I040-029-121353783-01**	**Health Provider**	:**CITICARE MEDICAL CENTER LLC** **Direct Access SP - YES**
Policy Holder	: **NISAL GURUNG**	**Doctor's Name**	:**DR Amaizah**
Payer Name	: **UNION INSURANCE COMPANY**	**Co-Insurance**	:
TPA	: **E CARE - Blue Network**	**Remarks**	:
Validity	: **02-01-2025** To **01-01-2026**		
Gender	: **Male**		
Date Of Birth	: **28-Feb-1989**		
Patient's Tel No	: **0509869230**		

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 : ORE THROAT , BODYPAIN , HEADACHE , LETHARGY AND COUGH WHICH IS DRY STRATED 03/04/25 NOW STARTED BLOOD STAINED MUCOUS HEMOPTYSIS SRATED 05/04/25 O/E : LOOK LETHARGIC FEBRILE TONSILLS ARE SWOLEN , RED WITH PUS POINTS HYPEREMIC PHARYN X CHEST WHEEZING **Duration:**

Vitals: Temp : 36.7 Bp :120 Pulse :86 Resp :18

Clinical Findings:

Diagnosis: J03.90 - Acute tonsillitis, unspecified,R04.2 - Hemoptysis,R06.2 - Wheezing,R50.9 - Fever, unspecified, **Date of Onset:**05/49/2025

Requested Investigations: 0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE,0005-111805-1021, CHLOROHISTOL 10MG,94640, AIRWAY INHALATION TREATMENT,0188-135906-2441, PULMICORT,96372, THER/PROPH/DIAG INJ SC/IM **Estimated Cost** :

Prescriptions: 0188-135907-2441 - (BUDESONIDE : 0.25 MG/ML) SUSPENSION FOR NEBULIZATION, **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 :** 05-Apr-2025

Signature : **Date** : 05-Apr-2025