Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	: **Surendra Kumar Chaudhri**	**Service Date**	:**08-Apr-2025**
Card No	: **I040-029-117537322-01**	**Health Provider**	:**CITICARE MEDICAL CENTER LLC**
Policy Holder	: **Surendra Kumar Chaudhri**	**Doctor's Name**	:**Humaira**
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	: **18-Apr-1988**		
Patient's Tel No	: **0562997905**		

Network : Green

Direct Access SP - YES

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 : sore throat fever since 2 days now due to that got blister over lipe and near nose **Duration:**

Vitals: Temp : 36.8 Bp :130 Pulse :78 Resp :18

Clinical Findings:

Diagnosis: B00.9 - Herpesviral infection, unspecified,T78.40XS - Allergy, unspecified, sequela, **Date of Onset** :08/14/2025

Estimated Cost :

Requested Investigations: 9, Consultation GP

Prescriptions: 0023-102407-0381 - (ACYCLOVIR : 3%) EYE OINTMENT,0195-123701-0391 - (CETIRIZINE HCL : 10 MG) FILM COATED TABLETS,0252-102404-1171 - (ACYCLOVIR : 200 MG) 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 : Humaira

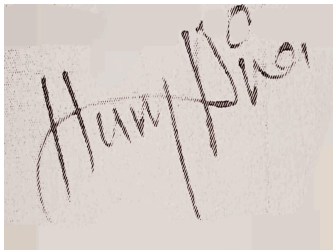
Stamp :

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

Patient 's signature{Parent if minor} :

Date : 08-Apr-2025

Signature :



Date : 08-Apr-2025