Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	: **SONAL MILITHA KALUTHARA LEKAMLAGE**	**Service Date**	:**10-Apr-2025** **Network** : Green
Card No	: **I040-029-119014962-01**	**Health Provider**	:**CITICARE MEDICAL CENTER LLC** **Direct Access SP - YES**
Policy Holder	: **SONAL MILITHA KALUTHARA LEKAMLAGE**	**Doctor's Name**	:**AISHA**
Payer Name	: **UNION INSURANCE COMPANY**	**Co-Insurance**	:
TPA	: **E CARE - Green Network**	**Remarks**	:
Validity	: **01-10-2024** To **30-09-2025**		
Gender	: **Male**		
Date Of Birth	: **21-Feb-1996**		
Patient's Tel No	: **0527763267**		

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 : patient came with high grade fever along with body ache and throat pain since morning oe throat is hyperemic chest is clear **Duration:**

Vitals: Temp : 37.3 Bp :121 Pulse :117 Resp :18

Clinical Findings:

Diagnosis: J02.9 - Acute pharyngitis, unspecified,R50.9 - Fever, unspecified,R05 - Cough, **Date of Onset** :10/02/2025

Requested Investigations: 85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,86140, C REACTIVE PROTEIN,9, Consultation GP **Estimated Cost** :

Prescriptions: 0005-116702-2481 - (DIPHENHYDRAMINE : 12.5 MG/5ML) SYRUP (SUGAR FREE),6705-602505-3801 - (HYDROXYPROPYLMETHYLCELLULOSE : 150 MG/ 30ML) SPRAY SOLUTION,0005-107001-0051 - (CAFFEINE : 65 MG) (PARACETAMOL : 500 MG) CAPLETS,0097-127405-0391 - (AZITHROMYCIN : 500 MG) FILM COATED TABLETS, **Estimated Cost** :

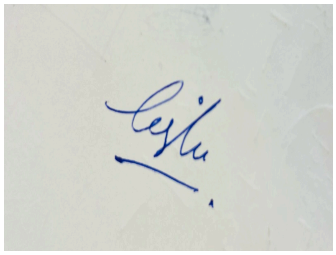
MEDICAL PRACTITIONER DECLARATION :

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.

Dr's Name : AISHA

Stamp :

Dr. Aisha Umer
Physician- General Practitioner
DHA- 40131439-002
CITICARE MEDICAL CENTER
DUBAI - U.A.E

Signature : 

Date : 10-Apr-2025

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.

Patient 's signature{Parent if minor} :

Date : 10-Apr-2025