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 :**12-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 : pc persistent symptoms of acute tonsillitis along with loose motion , epigastric burning , feel lethargic o/e : epigastric tenderness lookl ethargic ,dehydrated **Duration:**

Vitals: Temp : 36.8 Bp :118 Pulse :86 Resp :18

Clinical Findings:

Diagnosis: K29.00 - Acute gastritis without bleeding,R51.9 - Headache, unspecified,E86.0 - Dehydration,R19.7 - Diarrhea, unspecified, **Date of Onset** :12/20/2025

Requested Investigations: 96360, HYDRATION IV INFUSION INIT,2190-106618-1001, PARAFUSIV,0005-149902-1021, CLOFEN ,87338, IAAD EIA HPYLORI STOOL,0005-174202-0781, RISEK 40MG,0195-107704-0802, CEFTRIAXONE-TABUK IM,96372, THER/PROPH/DIAG INJ SC/IM,9, Consultation GP **Estimated Cost** :

Prescriptions: 0415-200001-1452 - (LOPERAMIDE : 2 MG) CAPSULES (HARD GELATIN),1162-699701-0391 - (ACETYLSALICYLIC ACID : 250 MG) (CAFFEINE : 65 MG) (PARACETAMOL : 250 MG) FILM COATED TABLETS,0219-533801-0392 - (ESOMEPRAZOLE (AS MAGNESIUM) : 20 MG) FILM COATED TABLETS,6619-608703-0831 - (SODIUM CHLORIDE : 0.52 G) (POTASSIUM CHLORIDE : 0.3 G) (SODIUM CITRATE : 0.58 G) (GLUCOSE ANHYDROUS : 2.7 G) POWDER FOR SOLUTION, **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

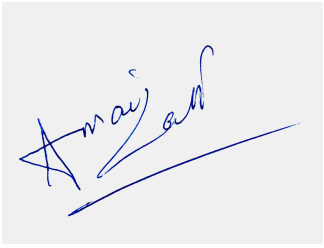
Stamp :

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

Patient 's signature{Parent if minor} :

Date : 12-Apr-2025

Signature :



Date : 12-Apr-2025