Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	**: SANJEEV KUMAR**	**Service Date**	**:25-Apr-2025**
Card No	**: I040-029-119986028-01**	**Health Provider**	**:CITICARE MEDICAL CENTER LLC**
Policy Holder	**: SANJEEV KUMAR**	**Doctor's Name**	**:Dr.Farhan Iyas**
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	**: 10-Feb-1986**		
Patient's Tel No	**: 0528360400**		

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 : history of insert a drop of rusting removal chemical in eyes in the morning now came with redness and irritation in the eye o/e there is no serious injury seen. **Duration:**

Vitals: Temp : 36.6 Bp :140 Pulse :70 Resp :0

Clinical Findings:

Diagnosis: T26.91XA - Corrosion of right eye and adnexa, part unsp, init encntr,R52 - Pain, unspecified, **Date of Onset :**25/16/2025

Estimated Cost :

Requested Investigations: 9, Consultation GP

Prescriptions: 4884-622202-1171 - (SERRAPEPTASE : 10 MG) TABLETS,0320-148701-1171 - (LORATADINE : 10 MG) TABLETS,0085-239201-0371 - (DEXAMETHASONE : 0.10%) (TOBRAMYCIN : 0.3%) EYE DROPS,

Estimated Cost :

MEDICAL PRACTITIONER DECLARATION :

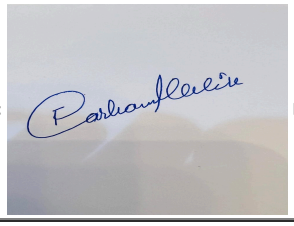
I declare that I am the patient's medical practitioner and that the particulars given are to the best of my knowledge true and correct.

Dr's Name : Dr.Farhan Iyas

Stamp :

Dr .Frahan Ilyas Malik
Physician-General Practitioner
DHA-06441782-001
CITICARE MEDICAL CENTER
DUBAI U.A.E

Signature :



Date : 25-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 : 25-Apr-2025