Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	: GANGA KERUNG	**Service Date**	:10-May-2025
Card No	: I040-029-113718932-01	**Health Provider**	:CITICARE MEDICAL CENTER LLC
Policy Holder	: GANGA KERUNG	**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	: 08-Oct-1981		
Patient's Tel No	: 0503621186		

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 : pain in throat body aches cold weakness sometime have fever blood pressure is high previously vitamin d is low **Duration:**

Vitals: Temp : 36.9 Bp :148 Pulse :86 Resp :18

Clinical Findings:

Diagnosis: J03.91 - Acute recurrent tonsillitis, unspecified,I10 - Essential (primary) hypertension,E55.9 - Vitamin D deficiency, unspecified,E78.00 - Pure hypercholesterolemia, unspecified,E79.0 - Hyperuricemia w/o signs of inflam arthrit and tophaceous dis,M54.5 - Low back pain, **Date of Onset** :10/10/2025

Requested Investigations: 85004, BLOOD COUNT AUTOMATED DIFFERENTIAL WBC COUNT,86140, C REACTIVE PROTEIN,80061, LIPID PANEL,84550, URIC ACID BLOOD,0005-149902-1021, CLOFEN ,96372, THER/PROPH/DIAG INJ SC/IM,9, Consultation GP **Estimated Cost** :

Prescriptions: 0097-142201-0391 - (DICLOFENAC POTASSIUM : 50 MG) FILM COATED TABLETS,0320-148701-1171 - (LORATADINE : 10 MG) TABLETS,0006-106601-0394 - (PARACETAMOL : 500 MG) FILM COATED TABLETS,0397-116207-0391 - (AMOXICILLIN : 500 MG) (CLAVULANIC ACID : 125 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.

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.Farhan Iyas

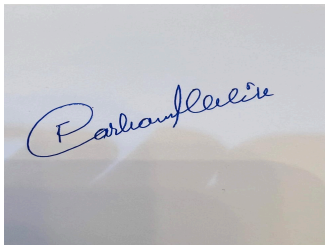
Stamp :

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

Patient 's signature{Parent if minor} :

Date : 10-May-2025

Signature :



Date : 10-May-2025