Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	**: GANGA KERUNG**
Card No	**: I040-029-113718932-01**
Policy Holder	**: GANGA KERUNG**
Payer Name	**: UNION INSURANCE COMPANY**
TPA	**: E CARE - Blue Network**
Validity	**: 02-01-2025** To **01-01-2026**
Gender	**: Male**
Date Of Birth	**: 08-Oct-1981**
Patient's Tel No	**: 0503621186**

Service Date **:11-May-2025** **Network** : Green

Health Provider **:CITICARE MEDICAL CENTER LLC** **Direct Access SP - YES**

Doctor's Name **:AISHA**

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

Vitals: Temp : 36.9 Bp :139 Pulse :86 Resp :18

Clinical Findings:

Diagnosis: J03.90 - Acute tonsillitis, unspecified,E55.9 - Vitamin D deficiency, unspecified,I10 - Essential (primary) hypertension, **Date of Onset** :11/03/2025

Requested Investigations: 9.01, Follow Up Consultation GP,0195-107704-0801, CEFTRIAXONE-TABUK IV,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE-(DEXAMETHASONE : 4 MG/ML) SOLUTION FOR INJECTION,96372, THER/PROPH/DIAG INJ SC/IM,96374, THER/PROPH/DIAG INJ IV PUSH,INJ064, VITAMIN D, INJECTION ,96372, INJECTION SERVICE-IM **Estimated Cost** :

Prescriptions: 1290-640420-1171 - (VITAMIN D3 (CHOLECALCIFEROL) : 10000 IU) 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.

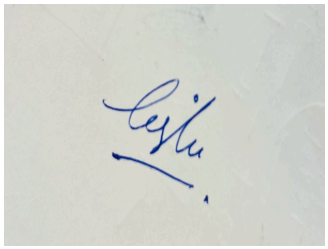
Dr's Name : AISHA

Stamp :

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

Patient 's signature{Parent if minor} :

Date : 11-May-2025

Signature : 

Date : 11-May-2025