Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	: **Rinson Vadekkathala Poulose**	**Service Date**	:**14-May-2025** **Network** : Green
Card No	: **I040-029-113719116-01**	**Health Provider**	:**CITICARE MEDICAL CENTER LLC** **Direct Access SP - YES**
Policy Holder	: **Rinson Vadekkathala Poulose**	**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	: **04-Apr-1982**		
Patient's Tel No	: **0553752382**		

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 right side of shoulder since 2 days 12/05l25 sore throat dry cough yellow sputum coming out headache body ache **Duration:**

Vitals: Temp : 36.8 Bp :117 Pulse :82 Resp :18

Clinical Findings:

Diagnosis: J06.9 - Acute upper respiratory infection, unspecified,M25.511 - Pain in right shoulder,R05 - Cough,R07.0 - Pain in throat,M54.5 - Low back pain, **Date of Onset** :14/16/2025

Requested Investigations: 85027, BLOOD COUNT COMPLETE AUTOMATED,86140, C REACTIVE PROTEIN,0005-149902-1021, CLOFEN ,96372, THER/PROPH/DIAG INJ SC/IM,0188-135906-2441, PULMICORT,94640, AIRWAY INHALATION TREATMENT,9, Consultation GP **Estimated Cost** :

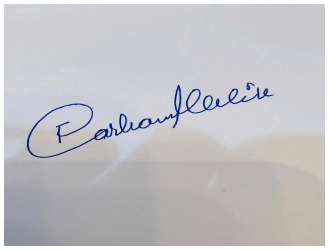
Prescriptions: 0397-116207-0391 - (AMOXICILLIN : 500 MG) (CLAVULANIC ACID : 125 MG) FILM COATED TABLETS,0006-106601-0394 - (PARACETAMOL : 500 MG) FILM COATED TABLETS,0027-265802-1161 - (BUTAMIRATE DIHYDROGEN CITRATE : 0.15% W/V) SYRUP,0320-148701-1171 - (LORATADINE : 10 MG) TABLETS,2093-596002-0431 - (DICLOFENAC DIETHYLAMINE : 23.2 MG / G) GEL,0097-142201-0391 - (DICLOFENAC POTASSIUM : 50 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 : Dr.Farhan Iyas **Stamp :**

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

Signature :  **Date** : 14-May-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** : 14-May-2025