## Administrative

## MEDICAL CLAIM FORM

## Claim Ref:

| | | | |
|---|---|---|---|
| **Patient Name** | : **AMAN SRIKOTI JALAM SINGH SRIKOTI** | **Service Date** | :**21-May-2025** **Network** : Green |
| **Card No** | : **I040-029-122594136-01** | **Health Provider** | :**CITICARE MEDICAL CENTER LLC** **Direct Access SP - YES** |
| **Policy Holder** | : **AMAN SRIKOTI JALAM SINGH SRIKOTI** | **Doctor's Name** | :**AISHA** |
| **Payer Name** | : **UNION INSURANCE COMPANY** | | |
| **TPA** | : **E CARE - Blue Network** | | |
| **Validity** | : **10-04-2025** To **12-01-2026** | | |
| **Gender** | : **Male** | | |
| **Date Of Birth** | : **06-Jul-2002** | | |
| **Patient's Tel No** | : **0527106520** | | |

**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 :** PATIENT CAME WITH COMPLAIN OF ITCHING AND CIRCULAR RASH ON FACE CHEST AT PUBIC AREA FOR 15 DAYS OE ITS IRREGULAR PATCH AND IRREGULAR MARGIN ALONG WITH DISCOLOURATION OF SKIN AS WELL HE HAS BEEN TAKING MEDICATION FOR THIS IISUE FOR LONG TIME **Duration:**

**Vitals:**Temp : 37 Bp :157 Pulse :100 Resp :18

**Clinical Findings:**

**Diagnosis:** L92.3 - Foreign body granuloma of the skin and subcutaneous tissue,B00.0 - Eczema herpeticum,R21 - Rash and other nonspecific skin eruption,B36.8 - Other specified superficial mycoses, **Date of Onset** :21/39/2025

**Estimated Cost** :

**Requested Investigations:** 9, Consultation GP

**Prescriptions:** 2627-672101-0151 - (MICONAZOLE NITRATE : 20 MG/G) (MOMETASONE FUROATE : 1 MG/G) CREAM,0207-214402-0151 - (BETAMETHASONE : N/A) (CLOTRIMAZOLE : N/A) CREAM,0195-123701-0391 - (CETIRIZINE HCL : 10 MG) FILM COATED TABLETS,0005-119803-1171 - (PREDNISOLONE : 20 MG) TABLETS,0252-140201-0061 - (FLUCONAZOLE : 150 MG) CAPSULES, **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

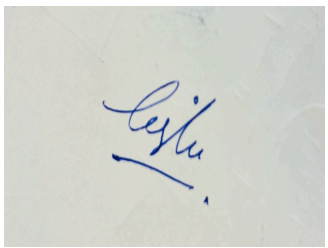
**Stamp :**

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

**Patient 's signature{Parent if minor}** :

**Date** : 21-May-2025

**Signature :**



**Date** : 21-May-2025