Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	**: DAWN EATON**
Card No	**: I040-029-113188091-01**
Policy Holder	**: DAWN EATON**
Payer Name	**: UNION INSURANCE COMPANY**
TPA	**: E CARE - Blue Network**
Validity	**: 03-03-2025** To **02-03-2026**
Gender	**: Female**
Date Of Birth	**: 16-Apr-1961**
Patient's Tel No	**: 0502489697**

Service Date **:22-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 : PT CAME WITH LEFT ANKEL PAIN AND SWELLING FOR TWO WEEKS OE THERE IS TENDERNESS WHILE TOUCHING MOVEMENTS ARE INTACT **Duration:**

Vitals: Temp : 36.1 Bp :144 Pulse :84 Resp :18

Clinical Findings:

Diagnosis: M25.572 - Pain in left ankle and joints of left foot,M25.472 - Effusion, left ankle,R52 - Pain, unspecified,L03.90 - Cellulitis, unspecified, **Date of Onset** :22/39/2025

Estimated Cost :

Requested Investigations: 9, Consultation GP

Prescriptions: 5193-122302-0391 - (ETORICOXIB : 120 MG) FILM COATED TABLETS,4884-622202-1171 - (SERRAPEPTASE : 10 MG) TABLETS,2093-596002-0431 - (DICLOFENAC DIETHYLAMINE : 23.2 MG / G) GEL, **Estimated Cost** :

MEDICAL PRACTITIONER DECLARATION :

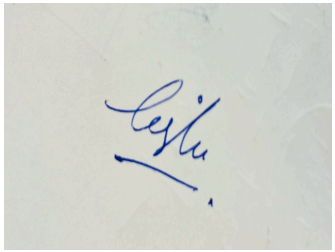
I declare that I am the patient's medical practitioner and that the particulars given are to the best of my knowledge true and correct.

Dr's Name : AISHA

Stamp :

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

Signature :



Date : 22-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 : 22-May-2025