Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	**: AMAN SRIKOTI JALAM SINGH SRIKOTI**
Card No	**: I040-029-122594136-01**
Policy Holder	**: AMAN SRIKOTI JALAM SINGH SRIKOTI**
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**

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 : 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:

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** :22/15/2025

Requested Investigations: 9, Consultation GP **Estimated Cost** :

Prescriptions: **Estimated Cost** :

MEDICAL PRACTITIONER DECLARATION :

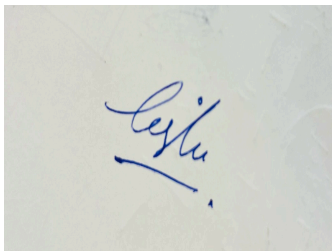
I declare that I am the patient's medical practitioner and that the particulars given are to the best of my knowledge true and correct.

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