Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	**: MEVAN DILSHAN PEIRIS BADDE LIYANAGE DON**
Card No	**: I040-029-118251299-01**
Policy Holder	**: MEVAN DILSHAN PEIRIS BADDE LIYANAGE DON**
Payer Name	**: UNION INSURANCE COMPANY**
TPA	**: E CARE - Blue Network**
Validity	**: 02-01-2025** To **01-01-2026**
Gender	**: Male**
Date Of Birth	**: 14-Jul-1995**
Patient's Tel No	**: 0526048378**

Service Date:02-Jun-2025 **Network** : Green

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

Doctor's Name **:Dr.Farhan Iyas**

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 : minor skin infection on the back of head since some days. o/e there is some rough patches which is dry seen. **Duration:**

Vitals: Temp : 36.9 Bp :130 Pulse :72 Resp :18

Clinical Findings:

Diagnosis: T78.40XD - Allergy, unspecified, subsequent encounter,R21 - Rash and other nonspecific skin eruption, **Date of Onset:**02/19/2025

Estimated Cost :

Requested Investigations: 9, Consultation GP

Prescriptions: 5252-027801-0151 - (BETAMETHASONE (AS DIPROPIONATE) : 0.5MG / G) (MICONAZOLE NITRATE : 20 MG/G) CREAM,0320-148701-1171 - (LORATADINE : 10 MG) 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.

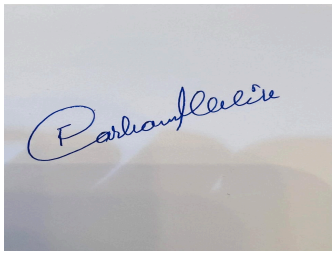
Dr's Name : Dr.Farhan Iyas

Stamp :

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

Patient 's signature{Parent : if minor}

Date : 02-Jun-2025

Signature : 

Date : 02-Jun-2025