Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	: **ANISHA ANIL KATTIKKARAN**	**Service Date**	**:06-Jun-2025**
Card No	: **I040-029-121542378-01**	**Health Provider**	**:CITICARE MEDICAL CENTER LLC**
Policy Holder	: **ANISHA ANIL KATTIKKARAN**	**Doctor's Name**	**:AISHA**
Payer Name	: **UNION INSURANCE COMPANY**	**Co-Insurance**	:
TPA	: **E CARE - Blue Network**	**Remarks**	:
Validity	: **02-01-2025** To **01-01-2026**		
Gender	: **Female**		
Date Of Birth	: **29-Sep-1999**		
Patient's Tel No	: **0553685056**		

Network : Green

Direct Access SP - YES

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 : PT CAME WITH FEVER BODY PAIN ALONG WITH THROAT PAIN RUNNY NOSE **Duration:** STARTEDTWO DAYS BACK THROAT IS HYPEREMIC PT LOOK DEHYDRATED AND WEAK

Vitals: Temp : 37.2 Bp :124 Pulse :78 Resp :18

Clinical Findings:

Diagnosis: J02.9 - Acute pharyngitis, unspecified,J30.89 - Other allergic rhinitis,R50.9 - Fever, unspecified,R52 - Pain, unspecified,E86.0 - Dehydration, **Date of Onset** :06/32/2025

Requested Investigations: 85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,86140, C REACTIVE PROTEIN,2190-106618-1001, PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION,0005-149902-1021, CLOFEN -(DICLOFENAC SODIUM : 75 MG/3ML) SOLUTION FOR INJECTION,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE-(DEXAMETHASONE : 4 MG/ML) SOLUTION FOR INJECTION,0439-152905-1001, LACTATED RINGERS INJECTION USP,0005-111805-1021, CHLOROHISTOL 10MG,96372, THER/PROPH/DIAG INJ SC/IM,96374, THER/PROPH/DIAG INJ IV PUSH,96360, HYDRATION IV INFUSION INIT **Estimated Cost** :

Prescriptions: 0005-119805-1172 - (PREDNISOLONE : 5 MG) TABLETS,0195-123701-0391 - (CETIRIZINE HCL : 10 MG) FILM COATED TABLETS,0005-107001-0051 - (CAFFEINE : 65 MG) (PARACETAMOL : 500 MG) CAPLETS,0097-127405-0392 - (AZITHROMYCIN : 500 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.

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

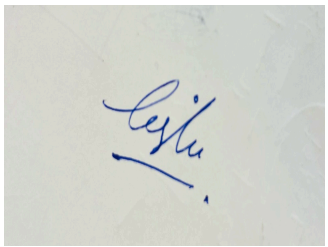
Stamp :

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

Patient 's signature{Parent if minor} :

Date : 06-Jun-2025

Signature :



Date : 06-Jun-2025