Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	**: LAKAI MITRA JATINDRA MITRA MITRA**
Card No	**: I040-029-113719086-01**
Policy Holder	**: LAKAI MITRA JATINDRA MITRA MITRA**
Payer Name	**: UNION INSURANCE COMPANY**
TPA	**: E CARE - Blue Network**
Validity	**: 02-01-2025** To **01-01-2026**
Gender	**: Male**
Date Of Birth	**: 05-Mar-1982**
Patient's Tel No	**: 508842935**

Service Date :10-Jun-2025 **Network** : Green

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

Doctor's Name **:DR Amaizah**

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 : **Duration** :

Vitals: Temp : 36.8 Bp :117 Pulse :80 Resp :18

Clinical Findings:

Diagnosis: R21 - Rash and other nonspecific skin eruption, **Date of Onset** : 10/27/2025

Requested Investigations: 85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,86140, C REACTIVE PROTEIN,82247, BILIRUBIN TOTAL,82040, ALBUMIN SERUM PLASMA/WHOLE BLOOD,9, Consultation GP **Estimated Cost** :

Prescriptions: 0005-119805-1173 - (PREDNISOLONE : 5 MG) TABLETS,0195-123701-0391 - (CETIRIZINE HCL : 10 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 : DR Amaizah

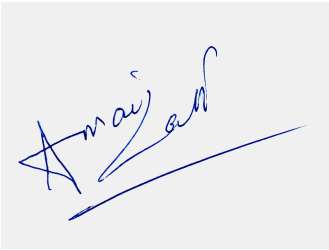
Stamp :

Dr. Amaizah Ishtiaq
General Practitioner
DHA: 98486553-001
CITICARE MEDICAL CENTER
DUBAI - U.A.E

Patient 's signature{Parent if minor} :

Date : 10-Jun-2025

Signature :



Date : 10-Jun-2025