## Administrative

## MEDICAL CLAIM FORM

## Claim Ref:

| | |
|---|---|
| **Patient Name** | **: PONWEERA ARACHIGE KASUN NAWANJANA PERERA** |
| **Card No** | **: I040-029-122554762-01** |
| **Policy Holder** | **: PONWEERA ARACHIGE KASUN NAWANJANA PERERA** |
| **Payer Name** | **: UNION INSURANCE COMPANY** |
| **TPA** | **: E CARE - Blue Network** |
| **Validity** | **: 15-04-2025** To **01-01-2026** |
| **Gender** | **: Male** |
| **Date Of Birth** | **: 27-Jun-2000** |
| **Patient's Tel No** | **: 0521805852** |

| | |
|---|---|
| **Service Date** | **:11-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 :** pc : hcx of nasal bleed from both nostrils m previousy recurrent rhinitis and flue like symptoms started10/06/25 poly uria plolyphagia family hx of hyperlipidemia and diabetese o/e : hyperthrophy of nasal terbinate both nostrils **Duration:**

**Vitals:**Temp : 36 Bp :120 Pulse :84 Resp :18

**Clinical Findings:**

**Diagnosis:** J30.9 - Allergic rhinitis, unspecified,J33.9 - Nasal polyp, unspecified,E11.65 - Type 2 diabetes mellitus with hyperglycemia,R04.0 - Epistaxis, **Date of Onset** :11/12/2025

**Requested Investigations:** 85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,86140, C REACTIVE PROTEIN,82948, REAGENT STRIP/BLOOD GLUCOSE,9, Consultation GP **Estimated Cost** :

**Prescriptions:** 5251-624304-3591 - (AZELASTINE HCL : 1 MG/G) (FLUTICASONE PROPIONATE : 0.365 MG/G) SUSPENSION FOR NASAL SPRAY,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.

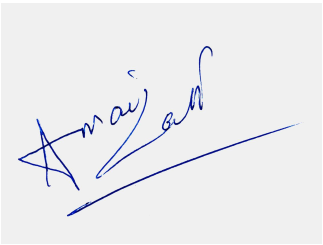
**PATIENT'S DECLARATION :**

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 :** 11-Jun-2025

**Signature :**  **Date** : 11-Jun-2025