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** :11/40/2025

Requested Investigations: 85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,86140, C REACTIVE PROTEIN,82948, REAGENT STRIP/BLOOD GLUCOSE,9, Consultation GP,82948, Glucose; blood, reagent strip,82947, GLUCOSE QUANTITATIVE BLOOD XCPT REAGENT STRIP **Estimated Cost** :

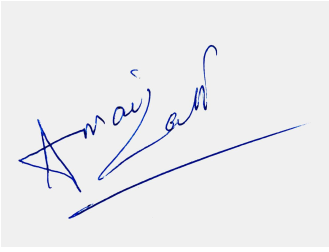
Prescriptions: 5251-624304-3591 - (AZELASTINE HCL : 1 MG/G) (FLUTICASONE PROPIONATE : 0.365 MG/G) SUSPENSION FOR NASAL SPRAY,0195-123701-0391 - (CETIRIZINE HCL : 10 MG) FILM COATED TABLETS, **Estimated Cost** :

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.

Dr's Name : DR Amaizah **Stamp :**

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

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