Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	**: NISAL GURUNG**
Card No	**: I040-029-121353783-01**
Policy Holder	**: NISAL GURUNG**
Payer Name	**: UNION INSURANCE COMPANY**
TPA	**: E CARE - Blue Network**
Validity	**: 02-01-2025** To **01-01-2026**
Gender	**: Male**
Date Of Birth	**: 28-Feb-1989**
Patient's Tel No	**: 0509869230**

Service Date **:14-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 : p/c: itching, pain and redness in eyes duration: since 3 to 4 days. he also have eye sight problem for which he is wearing glasses. **Duration:**

Vitals: Temp : 36.8 Bp :130 Pulse :86 Resp :18

Clinical Findings:

Diagnosis: H10.12 - Acute atopic conjunctivitis, left eye,H54.2X11 - Low vision r eye category 1, low vision left eye category 1, **Date of Onset** :14/09/2025

Estimated Cost :

Requested Investigations: 9, Consultation GP

Prescriptions: 0085-239201-0371 - (DEXAMETHASONE : 0.10%) (TOBRAMYCIN : 0.3%) EYE DROPS,0320-148701-1171 - (LORATADINE : 10 MG) TABLETS,

Estimated Cost :

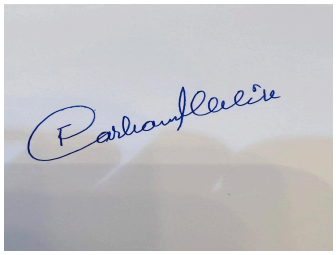
MEDICAL PRACTITIONER DECLARATION :

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.

Dr's Name : Dr.Farhan Iyas

Stamp :

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

Signature : 

Date : 14-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 : 14-Jun-2025