Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	**: NAREEKA KAINTH**
Card No	**: I040-029-121210616-01**
Policy Holder	**: NAREEKA KAINTH**
Payer Name	**: UNION INSURANCE COMPANY**
TPA	**: E CARE - Blue Network**
Validity	**: 05-02-2025** To **04-02-2026**
Gender	**: Female**
Date Of Birth	**: 07-Aug-1994**
Patient's Tel No	**: 0503567708**

Service Date **:16-Jun-2025** **Network** : Green

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

Doctor's Name **:AISHA**

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:GENERALIZE ITCHING AL OVER THE BODY **Duration** :

Vitals: Temp : 36.8 Bp :110 Pulse :66 Resp :18

Clinical Findings:

Diagnosis: R21 - Rash and other nonspecific skin eruption,B36.0 - Pityriasis versicolor, **Date of Onset** :16/56/2025

Requested Investigations: 0005-111805-1021, CHLOROHISTOL 10MG-(CHLORPHENIRAMINE MALEATE : 10 MG/ML) SOLUTION FOR INJECTION,96372, THER/PROPH/DIAG INJ SC/IM,9.01, Follow Up Consultation GP **Estimated Cost** :

Prescriptions: **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

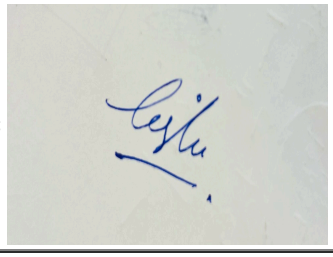
Stamp :

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

Patient 's signature{Parent if minor} :

Date : 16-Jun-2025

Signature :



Date : 16-Jun-2025