Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	**: JEET BAHADUR KHATRI**
Card No	**: I040-029-120209240-01**
Policy Holder	**: JEET BAHADUR KHATRI**
Payer Name	**: UNION INSURANCE COMPANY**
TPA	**: E CARE - Blue Network**
Validity	**: 02-01-2025** To **01-01-2026**
Gender	**: Male**
Date Of Birth	**: 02-Aug-1980**
Patient's Tel No	**: 0504753940**

Service Date :**26-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 : MOUTH ULCERS , ALLERGIES HOPC : **Duration** :

Vitals: Temp : 36.8 Bp :110 Pulse :90 Resp :18

Clinical Findings:

Diagnosis: K12.0 - Recurrent oral aphthae,R21 - Rash and other nonspecific skin eruption,D64.9 - Anemia, unspecified, **Date of Onset** :26/51/2025

Requested Investigations: 85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,86140, C REACTIVE PROTEIN,82785, GAMMAGLOBULIN IGE,0005-111805-1021, CHLOROHISTOL 10MG-(CHLORPHENIRAMINE MALEATE : 10 MG/ML) SOLUTION FOR INJECTION,96372, THER/PROPH/DIAG INJ SC/IM,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE-(DEXAMETHASONE : 4 MG/ML) SOLUTION FOR INJECTION,9, Consultation GP **Estimated Cost** :

Prescriptions: 0195-123701-0391 - (CETIRIZINE HCL : 10 MG) FILM COATED TABLETS,5254-830602-2401 - (VITAMIN B1 (THIAMINE) : 100 MG) (VITAMIN B6 (AS PYRIDOXINE HCL) : 200 MG) (VITAMIN B12 (CYANOCOBALAMIN) : 200 MCG) SUGAR COATED TABLETS,0355-254901-2301 - (SALICYLIC ACID : 1%) (ANTHRAQUINONE : 5%) SOLUTION (BUCCAL),0270-134501-1431 - (CETALKONIUM CHLORIDE : N/A) (CHOLINE SALICYLATE : 8.7%) BUCCAL GEL, **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

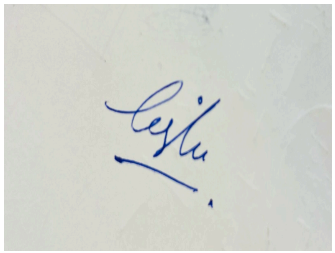
Stamp :

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

Patient 's signature{Parent if minor} :

Date : 26-Jun-2025

Signature :



Date : 26-Jun-2025