Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	**: simranjit rakesh kumar**	**Service Date**	**:11-Jul-2025**
Card No	**: I040-029-122224706-01**	**Health Provider**	**:CITICARE MEDICAL CENTER LLC**
Policy Holder	**: simranjit rakesh kumar**	**Doctor's Name**	**:AISHA**
Payer Name	**: UNION INSURANCE COMPANY**	**Co-Insurance**	**:**
TPA	**: E CARE - Blue Network**	**Remarks**	**:**
Validity	**: 18-02-2025 To 01-01-2026**		
Gender	**: Female**		
Date Of Birth	**: 09-Jul-2004**		
Patient's Tel No	**: 0508911367**		

Network : Green

Direct Access SP - YES

CONSULTATION	LAB/RADIOLOGY	PHYSIO	PHARMACY	IP	MATERNITY	DENTAL
10% max	NIL	NIL	NIL LIMIT	NIL	10%	NA

☐ **Acute** ☐ **Pre-existing and chronic** ☐ **Maternity**

Chief Complaints : pc : headache ,weakenss pt came with headache and fatique and dizziness for the last one month she look pale and dehydrated FOLLOW LOW HB HYPOTENSION pc : headache ,weakenss pt came with headache and fatique and dizziness for the last one month she look pale and dehydrated pc : headache ,weakenss pt came with headache and fatique and dizziness for the last one month she look pale and dehydrated pc : headache ,weakenss pt came with headache and fatique and dizziness for the last one month she look pale and dehydrated

Duration:

Vitals: Temp : 36.8 Bp :122 Pulse :84 Resp :18

Clinical Findings:

Diagnosis: D50.9 - Iron deficiency anemia, unspecified,R51.9 - Headache, unspecified,I95.9 - Hypotension, unspecified,E86.0 - Dehydration,

Date of Onset :11/28/2025

Requested Investigations: 0439-152905-1001, LACTATED RINGERS INJECTION USP,96372, THER/PROPH/DIAG INJ SC/IM,96360, HYDRATION IV INFUSION INIT,0005-149902-1021, CLOFEN - (DICLOFENAC SODIUM : 75 MG/3ML) SOLUTION FOR INJECTION

Estimated Cost :

Prescriptions:

Estimated Cost :

MEDICAL PRACTITIONER DECLARATION :

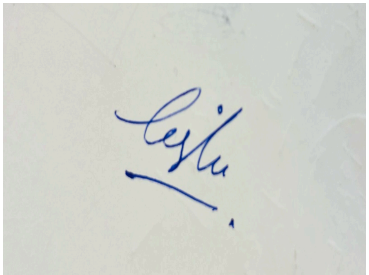
I declare that I am the patient's medical practitioner and that the particulars given are to the best of my knowledge true and correct.

Dr's Name : AISHA

Stamp :

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

Signature :



Date : 11-Jul-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-Jul-2025