Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	: **ANATH BANDHO MOZUMDER MOTHI LAL MOZUMDER**	**Service Date**	**:12-Jul-2025**
Card No	: **I005-029-118118930-01**	**Health Provider**	**:CITICARE MEDICAL CENTER LLC**
Policy Holder	: **ANATH BANDHO MOZUMDER MOTHI LAL MOZUMDER**	**Doctor's Name**	**:KEERTHANA**
Payer Name	: **DUBAI INSURANCE COMPANY**	**Co-Insurance**	:
TPA	: **E CARE - Blue Network**	**Remarks**	:
Validity	: **08-08-2024** To **07-08-2025**		
Gender	: **Male**		
Date Of Birth	: **10-Jul-1976**		
Patient's Tel No	: **0502547868**		

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 : Pt complaints of fever,headache,bodypain,cough ans sorethroat since today morning On examination chest clear,tonsils mild hyperemia No history of drug allergy No previous history **Duration:**

Vitals: Temp : 39 Bp :120 Pulse :102 Resp :18

Clinical Findings:

Diagnosis: R50.9 - Fever, unspecified,R51.9 - Headache, unspecified,R52 - Pain, unspecified,R05 - Cough, **Date of Onset :**12/06/2025

Requested Investigations: 2190-106618-1001, PARAFUSIV,0005-149902-1021, CLOFEN -(DICLOFENAC SODIUM : 75 MG/3ML) SOLUTION FOR INJECTION,0439-152905-1001, LACTATED RINGERS INJECTION USP,96374, THER/PROPH/DIAG INJ IV PUSH,96360, HYDRATION IV INFUSION INIT,96372, THER/PROPH/DIAG INJ SC/IM,9, Consultation GP **Estimated Cost :**

Prescriptions: 0152-181301-0391 - (MEFENAMIC ACID : 250 MG) FILM COATED TABLETS,0250-125808-1741 - (POVIDONE IODINE : 1%) GARGLE,0206-134003-1161 - (BROMHEXINE HYDROCHLORIDE : 4 MG/5ML) SYRUP,0006-106601-0392 - (PARACETAMOL : 500 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.

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 : KEERTHANA **Stamp :**

د. كيرثانا راني بادبيورايل ثارا
Dr. Keerthana Rani Padippurayil Thara
General Practitioner
License No.: 37864046-001
مركز سيتيكير الطبي ذ م م
CITICARE MEDICAL CENTER LLC

Patient 's signature{Parent : if minor} **Date :** 12-Jul-2025

Signature : **Date** : 12-Jul-2025