Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	: **PRIYANKA CHAMALIE IHALA GEDARA**	**Service Date**	:**14-Jul-2025**
Card No	: **I040-029-118720574-01**	**Health Provider**	:**CITICARE MEDICAL CENTER LLC**
Policy Holder	: **PRIYANKA CHAMALIE IHALA GEDARA**	**Doctor's Name**	:**AISHA**
Payer Name	: **UNION INSURANCE COMPANY**	**Co-Insurance**	
TPA	: **E CARE - Green Network**	**Remarks**	:
Validity	: **01-10-2024** To **30-09-2025**		
Gender	: **Female**		
Date Of Birth	: **20-Nov-1979**		
Patient's Tel No	: **0509202615**		

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

Network : Green

Direct Access SP - YES

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

Chief Complaints : general check up **Duration** :

Vitals: Temp : 36.6 Bp :140 Pulse :80 Resp :19

Clinical Findings:

Diagnosis: R53.1 - Weakness, **Date of Onset** : 14/20/2025

Estimated Cost :

Requested Investigations: 9, Consultation GP

Estimated Cost :

Prescriptions:

MEDICAL PRACTITIONER DECLARATION :

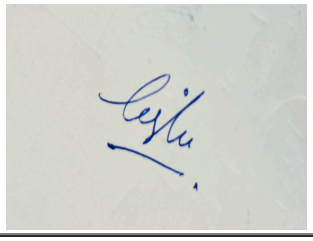
I declare that I am the patient's medical practitioner and that the particulars given are to the best of my knowledge true and correct.

Dr's Name : AISHA

Stamp :

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

Signature :



Date : 14-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 : 14-Jul-2025