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 **:17-Jul-2025** **Network** **:** Green

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

Doctor's Name **:Dr.Farhan Iyas**

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 : chief complaint: on investigation: high uric acid there is some white rashes over chest, armpit, and arms and finger. **Duration:**

Vitals: Temp : 36 Bp :120 Pulse :80 Resp :18

Clinical Findings:

Diagnosis: E79.0 - Hyperuricemia w/o signs of inflam arthrit and tophaceous dis,R21 - Rash and other nonspecific skin eruption,B36.0 - Pityriasis versicolor,L23.9 - Allergic contact dermatitis, unspecified cause, **Date of Onset** **:**17/26/2025

Estimated Cost **:**

Requested Investigations: 9, Consultation GP

Prescriptions: 0186-140201-1451 - (FLUCONAZOLE : 150 MG) CAPSULES (HARD GELATIN),8033-053401-0151 - (BETAMETHASONE (AS VALERATE) : 0.1% W/W) CREAM,0320-148701-1171 - (LORATADINE : 10 MG) TABLETS,0252-375701-0391 - (FEBUXOSTAT : 40 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.

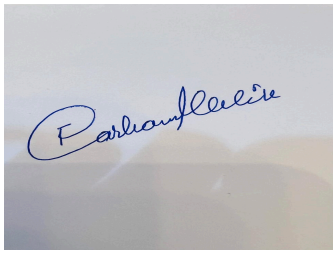
PATIENT'S DECLARATION :

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 **:** Dr.Farhan Iyas **Stamp :**

Dr .Frahan Ilyas Malik
Physician-General Practitioner
DHA-06441782-001
CITICARE MEDICAL CENTER
DUBAI U.A.E

Patient 's signature{Parent if minor} **:** **Date :** 17-Jul-2025

Signature :  **Date** **:** 17-Jul-2025