Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	**: PONWEERA ARACHIGE KASUN NAWANJANA PERERA**
Card No	**: I040-029-122554762-01**
Policy Holder	**: PONWEERA ARACHIGE KASUN NAWANJANA PERERA**
Payer Name	**: UNION INSURANCE COMPANY**
TPA	**: E CARE - Blue Network**
Validity	**: 15-04-2025** To **01-01-2026**
Gender	**: Male**
Date Of Birth	**: 27-Jun-2000**
Patient's Tel No	**: 0521805852**

Service Date **:19-Jul-2025** **Network** : Green

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

Doctor's Name **:KEERTHANA**

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 fever,headache,bodypain,running nose HOPC pt presented with complaints of fever associated with headache,bodypain and running nose since 2 days O\E Chest clear Tonsils normal No history of drug allergy Nil comorbs **Duration:**

Vitals: Temp : 36 Bp :114 Pulse :84 Resp :18

Clinical Findings:

Diagnosis: R50.9 - Fever, unspecified,R52 - Pain, unspecified,R51.9 - Headache, unspecified,J30.9 - Allergic rhinitis, unspecified, **Date of Onset** :19/09/2025

Requested Investigations: 0005-149902-1021, CLOFEN -(DICLOFENAC SODIUM : 75 MG/3ML) SOLUTION FOR INJECTION,0005-111805-1021, CHLOROHISTOL INJECTION,9, Consultation GP,96372, THER/PROPH/DIAG INJ SC/IM **Estimated Cost** :

Prescriptions: 2689-107001-0391 - (PARACETAMOL : 500 MG) (CAFFEINE : 65 MG) FILM COATED TABLETS,0205-290301-0391 - (LEVOCETIRIZINE (DIHCL OR HCL) : 5 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.

Dr's Name : KEERTHANA **Stamp :**

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

Signature :  **Date** : 19-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 :** 19-Jul-2025