Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	: **VIJAY DAYAL SINGH**	**Service Date**	:**31-Jul-2025** **Network** : Green
Card No	: **I040-029-120878619-01**	**Health Provider**	:**CITICARE MEDICAL CENTER LLC** **Direct Access SP - YES**
Policy Holder	: **VIJAY DAYAL SINGH**	**Doctor's Name**	:**AISHA**
Payer Name	: **UNION INSURANCE COMPANY**	**Co-Insurance**	:
TPA	: **E CARE - Blue Network**	**Remarks**	:
Validity	: **22-08-2024** To **21-08-2025**		
Gender	: **Male**		
Date Of Birth	: **23-Oct-1998**		
Patient's Tel No	: **0567284544**		

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 : VERTIGO VOMITING NAUSEA **Duration :**

Vitals: Temp : 37 Bp :140 Pulse :82 Resp :18

Clinical Findings:

Diagnosis: I10 - Essential (primary) hypertension,H81.319 - Aural vertigo, unspecified ear,R52 - Pain, unspecified,R11.11 - Vomiting without nausea, **Date of Onset** :31/35/2025

Requested Investigations: 0005-149902-1021, CLOFEN -(DICLOFENAC SODIUM : 75 MG/3ML) SOLUTION FOR INJECTION,0005-150403-1021, PREMOSAN -(METOCLOPRAMIDE : 10 MG/2ML) SOLUTION FOR INJECTION,9, Consultation GP,96372, THER/PROPH/DIAG INJ SC/IM **Estimated Cost** :

Estimated Cost :

Prescriptions: 0095-115904-1171 - (AMLODIPINE : 5MG) TABLETS,

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 : AISHA

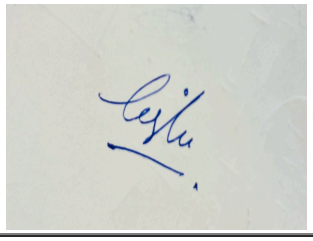
Stamp :

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

Patient 's signature{Parent if minor} :

Date : 31-Jul-2025

Signature :



Date : 31-Jul-2025