Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	: **PRAKASH BAHADUR RANABHAT**	**Service Date**	:**03-Aug-2025**
Card No	: **I040-029-118854865-01**	**Health Provider**	:**CITICARE MEDICAL CENTER LLC**
Policy Holder	: **PRAKASH BAHADUR RANABHAT**	**Doctor's Name**	:**DR Amaizah**
Payer Name	: **UNION INSURANCE COMPANY**	**Co-Insurance**	:
TPA	: **E CARE - Blue Network**	**Remarks**	:
Validity	: **02-01-2025** To **01-01-2026**		
Gender	: **Male**		
Date Of Birth	: **20-Feb-1986**		
Patient's Tel No	: **0525258101**		

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 : PC : SEVRE PAIN IN HEEL AND ANKLE OF RT FOOT , PAIN IS 08 ON PAIN SCORE ASSOCIATED WITH SWELLING OF HEEL AND ANKLE NO HX OF TRUAMA OR INJURY WORKS AT RECEPTION KEEP SITTING MOST OF TIOME O/ E: VARICOSE VEINS SWELLING TENDER HEEL AND ANKLE **Duration:**

Vitals: Temp : 36.1 Bp :120 Pulse :64 Resp :22

Clinical Findings:

Diagnosis: R52 - Pain, unspecified,M13.179 - Monoarthritis, not elsewhere classified, unsp ankle and foot,I83.219 - Varicos vn of r low extrem w ulc of unsp site and inflam,E78.5 - Hyperlipidemia, unspecified,Z13.1 - Encounter for screening for diabetes mellitus, **Date of Onset** :03/34/2025

Requested Investigations: 86140, C REACTIVE PROTEIN,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE,0005-149902-1021, CLOFEN ,80061, LIPID PANEL,84550, URIC ACID BLOOD,96372, THER/PROPH/DIAG INJ SC/IM,82947, GLUCOSE QUANTITATIVE BLOOD XCPT REAGENT STRIP,85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,9, Consultation GP,85378, FIBRIN DGRADJ PRODUCTS D DIMER QUAL/SEMIQUAN **Estimated Cost** :

Prescriptions: 0201-124202-0341 - (ASPIRIN : 75 MG) ENTERIC COATED TABLETS,0027-142201-0832 - (DICLOFENAC POTASSIUM : 50 MG) POWDER FOR SOLUTION,0186-143701-0062 - (CELECOXIB : 200 MG) CAPSULES, **Estimated Cost** :

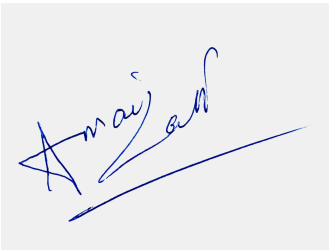
MEDICAL PRACTITIONER DECLARATION :

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 : DR Amaizah

Stamp :

Dr. Amaizah Ishtiaq
General Practitioner
DHA: 98486553-001
CITICARE MEDICAL CENTER
DUBAI - U.A.E

Signature : 

Date : 03-Aug-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 : 03-Aug-2025