Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	**: NISAL GURUNG**
Card No	**: I040-029-121353783-01**
Policy Holder	**: NISAL GURUNG**
Payer Name	**: UNION INSURANCE COMPANY**
TPA	**: E CARE - Blue Network**
Validity	**: 02-01-2025** To **01-01-2026**
Gender	**: Male**
Date Of Birth	**: 28-Feb-1989**
Patient's Tel No	**: 0509869230**

Service Date **:11-Aug-2025** **Network** : Green

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

Doctor's Name **:AISHA**

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 : dizziness ,vertigo pt came with the complain of headache along with generalize weakness and and vertigo started two weeks back he is not taking meals properly o/e he is dehydrated and weak pmh: none **Duration:**

Vitals: Temp : 36 Bp :120 Pulse :70 Resp :18

Clinical Findings:

Diagnosis: E78.01 - Familial hypercholesterolemia,R73.9 - Hyperglycemia, unspecified,G44.011 - Episodic cluster headache, intractable,E86.0 - Dehydration, **Date of Onset** :11/37/2025

Requested Investigations: 85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,80061, LIPID PANEL,82947, GLUCOSE QUANTITATIVE BLOOD XCPT REAGENT STRIP,0439-152905-1001, LACTATED RINGERS INJECTION USP,96360, HYDRATION IV INFUSION INIT,0005-149902-1021, CLOFEN ,96372, THER/PROPH/DIAG INJ SC/IM,9, Consultation GP **Estimated Cost** :

Prescriptions: **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 : AISHA

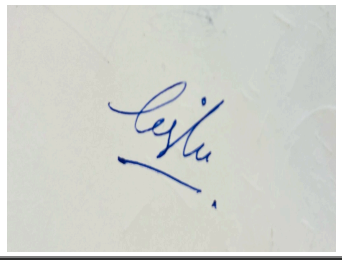
Stamp :

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

Patient 's signature{Parent if minor} :

Date : 11-Aug-2025

Signature :



Date : 11-Aug-2025