Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	: ANISHA ANIL KATTIKKARAN
Card No	: I040-029-121542378-01
Policy Holder	: ANISHA ANIL KATTIKKARAN
Payer Name	: UNION INSURANCE COMPANY
TPA	: E CARE - Blue Network
Validity	: 02-01-2025 To 01-01-2026
Gender	: Female
Date Of Birth	: 29-Sep-1999
Patient's Tel No	: 0553685056

Service Date :18-Aug-2025 **Network** : Green

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

Doctor's Name :DR Amaizah

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 : **Duration** :

Vitals: Temp : 36.4 Bp :110 Pulse :76 Resp :18

Clinical Findings:

Diagnosis: J30.9 - Allergic rhinitis, unspecified,J01.41 - Acute recurrent pansinusitis,J02.9 - Acute pharyngitis, unspecified,R51.9 - Headache, unspecified,R06.2 - Wheezing, **Date of Onset** :18/10/2025

Requested Investigations: 0005-111805-1021, CHLOROHISTOL 10MG-(CHLORPHENIRAMINE MALEATE : 10 MG/ML) SOLUTION FOR INJECTION,94640, AIRWAY INHALATION TREATMENT,0188-135906-2441, PULMICORT,96372, THER/PROPH/DIAG INJ SC/IM,9, Consultation GP **Estimated Cost** :

Prescriptions: 0207-395404-0391 - (MONTELUKAST (AS SODIUM) : 10 MG) FILM COATED TABLETS,8132-107203-1171 - (PARACETAMOL : 500 MG) (PSEUDOEPHEDRINE : 30 MG) TABLETS,0188-272101-0792 - (BUDESONIDE : 320 MCG/DOSE) (FORMOTEROL FUMARATE : 9 MCG/DOSE) POWDER FOR INHALATION, **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 Amaizah

Stamp :

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

Patient 's signature{Parent if minor} :

Date : 18-Aug-2025

Signature :

Date : 18-Aug-2025