Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	: **PARTHASARATHY KATANMAR WEETIL KARUNAKARAN KATANMAR**	**Service Date**	:**18-Aug-2025** **Network** : Green
Card No	: **I040-029-122411046-01**	**Health Provider**	:**CITICARE MEDICAL CENTER LLC** **Direct Access SP - YES**
Policy Holder	: **PARTHASARATHY KATANMAR WEETIL KARUNAKARAN KATANMAR**	**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	: **31-May-1968**		
Patient's Tel No	: **0558518126**		

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 : SNEEZING , ALLERGIC RHINITIS, AND RUNNY NOSE STARTED 17/08/25 **Duration:**
O/E : LOOK IRRITABLE

Vitals: Temp : 36.8 Bp :150 Pulse :80 Resp :18

Clinical Findings:

Diagnosis: J30.9 - Allergic rhinitis, unspecified,R05 - Cough,R52 - Pain, unspecified,R03.0 - Elevated blood-pressure reading, w/o diagnosis of htn, **Date of Onset** :18/36/2025

Requested Investigations: 85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,86140, C REACTIVE PROTEIN,9, Consultation GP **Estimated Cost** :

Prescriptions: 5915-640420-0061 - (VITAMIN D3 (CHOLECALCIFEROL) : 10000 IU) CAPSULES,0005-107201-0051 - (PARACETAMOL : 325 MG) (PSEUDOEPHEDRINE : 30 MG) CAPLETS,0207-379203-1171 - (AMLODIPINE (AS BESYLATE) : 5MG) TABLETS,0195-123701-0391 - (CETIRIZINE HCL : 10 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 : DR Amaizah **Stamp :**

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

Signature : **Date** : 18-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 :** 18-Aug-2025