Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	**: GANGA KERUNG**
Card No	**: I040-029-113718932-01**
Policy Holder	**: GANGA KERUNG**
Payer Name	**: UNION INSURANCE COMPANY**
TPA	**: E CARE - Blue Network**
Validity	**: 02-01-2025** To **01-01-2026**
Gender	**: Male**
Date Of Birth	**: 08-Oct-1981**
Patient's Tel No	**: 0503621186**

Service Date **:19-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 : dizziness , vertigo pt came with continous dizziness and vertigo started three **Duration:** days back he has high blood pressure but not taking medication

Vitals: Temp : 36.6 Bp :140 Pulse :88 Resp :18

Clinical Findings:

Diagnosis: I10 - Essential (primary) hypertension,H81.313 - Aural vertigo, bilateral, **Date of Onset** **:**19/27/2025

Estimated Cost :

Requested Investigations: 9, Consultation GP

Estimated Cost :

Prescriptions: 1291-380702-1171 - (BETAHISTINE HCL : 8 MG) TABLETS,

MEDICAL PRACTITIONER DECLARATION :

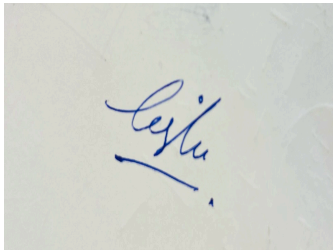
I declare that I am the patient's medical practitioner and that the particulars given are to the best of my knowledge true and correct.

Dr's Name : AISHA

Stamp :

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

Signature :



Date : 19-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 : 19-Aug-2025