Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	**: PUPUT ADI CANDRA**
Card No	**: I040-029-117763282-01**
Policy Holder	**: PUPUT ADI CANDRA**
Payer Name	**: UNION INSURANCE COMPANY**
TPA	**: E CARE - Blue Network**
Validity	**: 02-01-2025** To **01-01-2026**
Gender	**: Female**
Date Of Birth	**: 03-Jan-2003**
Patient's Tel No	**: 0562363186**

Service Date **:20-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 : high grade fever , post auricular lymphnode enlargment right side pt came with the complain of high grade fever along with lymph node enlargement started yestewrday there is swelling and pain on touch throat is mild hyperemic chest is clear allergies : none **Duration:**

Vitals: Temp : 38 Bp :110 Pulse :90 Resp :18

Clinical Findings:

Diagnosis: J03.90 - Acute tonsillitis, unspecified,R59.0 - Localized enlarged lymph nodes,R50.9 - Fever, unspecified,R07.0 - Pain in throat,I95.9 - Hypotension, unspecified, **Date of Onset** :20/25/2025

Requested Investigations: 85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,86140, C REACTIVE PROTEIN,2190-106618-1001, PARAFUSIV,96365, THER/PROPH/DIAG IV INF INIT,0384-111908-1001, SODIUM CHLORIDE B.P.,96360, HYDRATION IV INFUSION INIT,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE,96372, THER/PROPH/DIAG INJ SC/IM,0005-149902-1021, CLOFEN ,9, Consultation GP **Estimated Cost** :

Prescriptions: 0250-125820-3931 - (POVIDONE IODINE : 1%) MOUTHWASH-SOLUTION,0005-119803-1171 - (PREDNISOLONE : 20 MG) TABLETS,0397-116207-0391 - (AMOXICILLIN : 500 MG) (CLAVULANIC ACID : 125 MG) FILM COATED TABLETS,0005-107001-0052 - (CAFFEINE : 65 MG) (PARACETAMOL : 500 MG) CAPLETS, **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

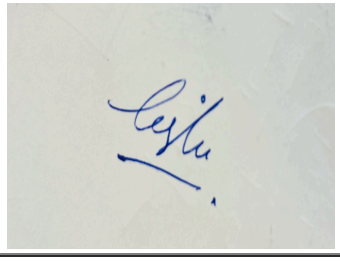
Stamp :

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

Patient 's signature{Parent if minor} :

Date : 20-Aug-2025

Signature :



Date : 20-Aug-2025