

Administrative

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 :21-Aug-2025

Health Provider :CITICARE MEDICAL CENTER LLC

Doctor's Name :AISHA

Co-Insurance :

CONSULTATION	LAB/RADIOLOGY	PHYSIO	PHARMACY	IP	MATERNITY	DENTAL
10% max	NIL	NIL	NIL LIMIT	NIL	10%	NA

Remarks :

Network : Green

Direct Access SP - YES

☐ 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 follow up no pain ,no fever

Vitals:Temp : 37.2 Bp :110 Pulse :94 Resp :18

Clinical Findings:

Diagnosis: J03.90 - Acute tonsillitis, unspecified,R59.0 - Localized enlarged lymph nodes,R50.9 - Fever, unspecified,E86.0 - Dehydration,R07.0 - Pain in throat,Date of Onset :21/29/2025

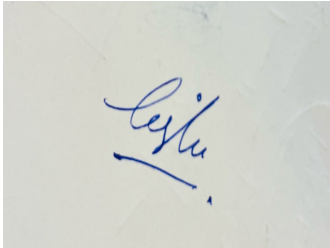
Requested Investigations: 2190-106618-1001, PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION,96365, THER/PROPH/DIAG IV INF INIT,0384-111908-1001, SODIUM CHLORIDE B.P.,96360, HYDRATION IV INFUSION INIT,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE,0005-149902-1021, CLOFEN ,96372, THER/PROPH/DIAG INJ SC/IM,9.01, Follow Up Consultation GP

Estimated Cost :

Prescriptions:

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

Signature :

Stamp :

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

Date : 21-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 : Aug-2025