Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	: **FETHI ACHI**	**Service Date**	:**13-Sep-2024** **Network** : Green
Card No	: **I040-029-121180791-01**	**Health Provider**	:**CITICARE MEDICAL CENTER LLC** **Direct Access SP - YES**
Policy Holder	: **FETHI ACHI**	**Doctor's Name**	:**Humaira**
Payer Name	: **UNION INSURANCE COMPANY**	**Co-Insurance**	
TPA	: **E CARE - Blue Network**		
Validity	: **08-08-2024** To **01-01-2025**	**Remarks**	:
Gender	: **Male**		
Date Of Birth	: **17-Nov-1999**		
Patient's Tel No	: **051127489**		

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 : co fever on and off taking penadol at home dry cough running nose bodyache **Duration:**
9th sep. 2024 oe enlarge tonsills chest is congested no added sounds restless

Vitals: Temp : 36.9 Bp :120 Pulse :63 Resp :18

Clinical Findings:

Diagnosis: R50.9 - Fever, unspecified,J06.9 - Acute upper respiratory infection, unspecified,R05 - Cough,K29.00 - Acute gastritis without bleeding, **Date of Onset** :13/45/2024

Requested Investigations: 85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,86140, C REACTIVE PROTEIN,0195-107704-0801, CEFTRIAXONE-TABUK IV,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE-(DEXAMETHASONE : 4 MG/ML) SOLUTION FOR INJECTION,96365, THER/PROPH/DIAG IV INF INIT,96372, THER/PROPH/DIAG INJ SC/IM,0188-135906-2441, PULMICORT-(BUDESONIDE : 0.5 MG/ML) SUSPENSION FOR NEBULIZATION,94640, AIRWAY INHALATION TREATMENT,9, Consultation GP,0195-107704-0802, CEFTRIAXONE-TABUK IM,96372, THER/PROPH/DIAG INJ SC/IM **Estimated Cost** :

Prescriptions: 0102-169701-1161 - (AMMONIUM CHLORIDE : N/A) (DIPHENHYDRAMINE : N/A) SYRUP,0005-107001-0051 - (CAFFEINE : 65 MG) (PARACETAMOL : 500 MG) CAPLETS,0097-127405-0391 - (AZITHROMYCIN : 500 MG) FILM COATED 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.

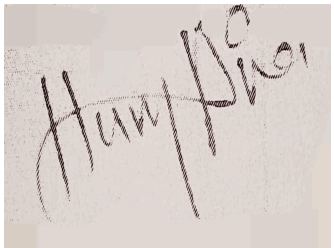
PATIENT'S DECLARATION :

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 : Humaira **Stamp :**

Dr. Humaira Mumtaz
General Practitioner
DHA No: 54155530-002
CITICARE MEDICAL CENTER LLC
DUBAI - U.A.E.

Patient 's signature{Parent if minor} : **Date** : 13-Sep-2024

Signature :  **Date** : 13-Sep-2024