Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	**: Janet Muthoki Peter**
Card No	**: I005-029-121227413-01**
Policy Holder	**: Janet Muthoki Peter**
Payer Name	**: DUBAI INSURANCE COMPANY**
TPA	**: E CARE - Blue Network**
Validity	**: 14-08-2024** To **12-05-2025**
Gender	**: Female**
Date Of Birth	**: 14-Oct-1998**
Patient's Tel No	**: 0543546130**

Service Date **:28-Sep-2024** **Network** : Green

Health Provider **:CITICARE MEDICAL CENTER LLC** **Direct Access SP - YES**

Doctor's Name **:AHSAN HUSSAIN**

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: FOLLOW UP WITH REPORTS POTASSIUM 5.5 HIGHER SIDE MUCUS THREAD POSITIVE IN URINE **Duration:**

Vitals: Temp : 36.3 Bp :125 Pulse :93 Resp :18

Clinical Findings:

Diagnosis: N39.0 - Urinary tract infection, site not specified,E87.5 - Hyperkalemia,R53.1 - Weakness, **Date of Onset** :28/20/2024

Requested Investigations: 0005-107704-0802, TRIAXONE I.V.-(CEFTRIAXONE : 1 G) POWDER FOR INJECTION,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,82947-1, GRBS,9.01, Follow Up Consultation GP **Estimated Cost** :

Prescriptions: 1947-548101-0081 - (CRANBERRY EXTRACT : 120 MG) CHEWABLE TABLETS,0139-116206-1171 - (CLAVULANIC ACID : 125 MG) (AMOXICILLIN : 875 MG) 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 : AHSAN HUSSAIN

Stamp :

Dr. Ahsan Hussain
General Practitioner
DHA No: 87543658-001
CITICARE MEDICAL CENTER LLC
DUBAI - U.A.E.

Signature :

Date : 28-Sep-2024

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 : 28-Sep-2024