Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	: MUKESH KUMAR KARAN SINGH	**Service Date**	:22-Oct-2024
Card No	: I040-029-121464896-01	**Health Provider**	:CITICARE MEDICAL CENTER LLC
Policy Holder	: MUKESH KUMAR KARAN SINGH	**Doctor's Name**	:Humaira
Payer Name	: UNION INSURANCE COMPANY	**Co-Insurance**	:
TPA	: E CARE - Blue Network	**Remarks**	:
Validity	: 02-10-2024 To 01-01-2025		
Gender	: Male		
Date Of Birth	: 05-Jan-1978		
Patient's Tel No	: 0509298696		

Network : Green

Direct Access SP - YES

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 dark colour of urine painful urination 15th oct 2024 oe chest is clear no added sounds restless **Duration:**

Vitals: Temp : 36.4 Bp :146 Pulse :82 Resp :18

Clinical Findings:

Diagnosis: N39.0 - Urinary tract infection, site not specified,R30.9 - Painful micturition, unspecified,R50.9 - Fever, unspecified, **Date of Onset** :22/27/2024

Requested Investigations: 9, Consultation GP,85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,86140, C REACTIVE PROTEIN,81001, URNLS DIP STICK/TABLET REAGENT AUTO MICROSCOPY,0195-107704-0801, CEFTRIAXONE-TABUK IV,96365, THER/PROPH/DIAG IV INF INIT,0005-149902-1021, CLOFEN -(DICLOFENAC SODIUM : 75 MG/3ML) SOLUTION FOR INJECTION,96372, THER/PROPH/DIAG INJ SC/IM,0102-152902-1001, LACTATED RINGERS INJECTION USP,96360, HYDRATION IV INFUSION INIT **Estimated Cost** :

Prescriptions: 0097-658501-0252 - (TARTARIC ACID : 0.89G) (SODIUM BICARBONATE : 1.76G) (CRANBERRY EXTRACT : 0.25 G) (TRI SODIUM CITRATE ANHYDROUS : 0.63G) (CITRIC ACID ANHYDROUS : 0.72G) EFFERVESCENT GRANULES,0005-107001-0051 - (CAFFEINE : 65 MG) (PARACETAMOL : 500 MG) CAPLETS,0195-116604-0391 - (METRONIDAZOLE : 500 MG) FILM COATED TABLETS,3114-482003-0391 - (CIPROFLOXACIN (AS HYDROCHLORIDE) : 500 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

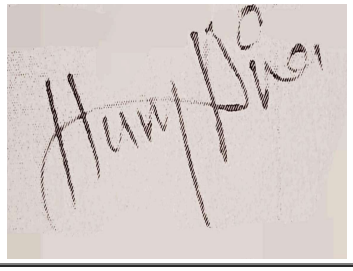
Stamp :

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

Patient 's signature{Parent if minor} :

Date : 22-Oct-2024

Signature :



Date : 22-Oct-2024