Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	: **ANITA MAGAR DHANJIT MAGAR**	**Service Date**	:**29-Oct-2024**
Card No	: **I040-029-119014964-01**	**Health Provider**	:**CITICARE MEDICAL CENTER LLC**
Policy Holder	: **ANITA MAGAR DHANJIT MAGAR**	**Doctor's Name**	:**AHSAN HUSSAIN**
Payer Name	: **UNION INSURANCE COMPANY**	**Co-Insurance**	
TPA	: **E CARE - Green Network**	**Remarks**	:
Validity	: **01-10-2024** To **30-09-2025**		
Gender	: **Female**		
Date Of Birth	: **20-Oct-1996**		
Patient's Tel No	: **0544398628**		

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 : PC: BURNING URINE PAIN IN URINE FEVER **Duration :**

Vitals: Temp : 36.7 Bp :100 Pulse :72 Resp :18

Clinical Findings:

Diagnosis: N39.0 - Urinary tract infection, site not specified,R52 - Pain, unspecified, **Date of Onset** :29/10/2024

Requested Investigations: 0005-107704-0802, TRIAXONE I.V.-(CEFTRIAXONE : 1 G) POWDER FOR INJECTION,96365, THER/PROPH/DIAG IV INF INIT,2190-106618-1001, PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION,86140, C REACTIVE PROTEIN,9, Consultation GP,81001, URNLS DIP STICK/TABLET REAGENT AUTO MICROSCOPY **Estimated Cost** :

Prescriptions: 5278-440704-0452 - (FOSFOMYCIN (AS TROMETAMOL) : 3 G) GRANULES,0054-103201-0391 - (CIPROFLOXACIN : 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 : AHSAN HUSSAIN **Stamp :**

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

Patient 's signature{Parent if minor} : **Date :** 29-Oct-2024

Signature : **Date** : 29-Oct-2024