Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	**: ISIDORA THEODOROU**
Card No	**: I005-029-112387445-02**
Policy Holder	**: ISIDORA THEODOROU**
Payer Name	**: DUBAI INSURANCE COMPANY**
TPA	**: E CARE - Blue Network**
Validity	**: 01-09-2024** To **31-08-2025**
Gender	**: Female**
Date Of Birth	**: 04-Oct-1978**
Patient's Tel No	**: 0544448193**

Service Date **:17-Nov-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: cough with asthmatic wheeze started today 17/11/2024 runny nose **Duration :**

Vitals: Temp : 36.7 Bp :90 Pulse :84 Resp :18

Clinical Findings:

Diagnosis: J20.9 - Acute bronchitis, unspecified,J45.991 - Cough variant asthma,J06.9 - Acute upper respiratory infection, unspecified,R07.1 - Chest pain on breathing,R06.2 - Wheezing, **Date of Onset** **:**17/42/2024

Requested Investigations: 0195-107704-0801, CEFTRIAXONE-TABUK IV,96365, THER/PROPH/DIAG IV INF INIT,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE,96372, THER/PROPH/DIAG INJ SC/IM,0188-135906-2441, PULMICORT,94640, AIRWAY INHALATION TREATMENT,2190-106618-1001, PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION,0005-149902-1021, CLOFEN ,85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,86140, C REACTIVE PROTEIN,9, Consultation GP **Estimated Cost :**

Prescriptions: 0195-395404-0391 - (MONTELUKAST (AS SODIUM : 10 MG FILM COATED TABLETS,0027-265802-1161 - (BUTAMIRATE DIHYDROGEN CITRATE : 0.15% W/V SYRUP,0005-128802-1971 - (XYLOMETAZOLINE HYDROCHLORIDE : 0.1% LIQUID FOR SPRAY (NASAL,0252-185801-0391 - (DIPHENHYDRAMINE : 25 MG) (PARACETAMOL : 500 MG) (PSEUDOEPHEDRINE : 30 MG) FILM COATED TABLETS,0013-127405-0391 - (AZITHROMYCIN : 500 MG FILM COATED TABLETS,0195-123701-0391 - (CETIRIZINE HCL : 10 MG) FILM COATED TABLETS, **Estimated Cost :**

MEDICAL PRACTITIONER DECLARATION :

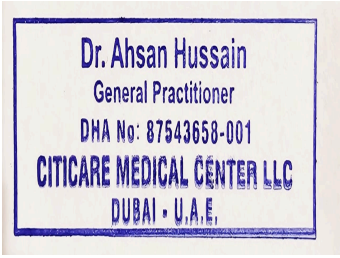
I declare that I am the patient's medical practitioner and that the particulars given are to the best of my knowledge true and correct.

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 : AHSAN HUSSAIN

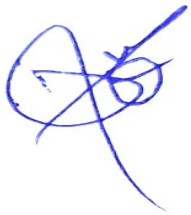
Stamp :



Patient 's signature{Parent if minor} :

Date : 17-Nov-2024

Signature :



Date : 17-Nov-2024