

Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name

: PENINNAH MUTUWA

Card No

: I040-029-116817510-01

Policy Holder

: PENINNAH MUTUWA

Payer Name

: UNION INSURANCE COMPANY

TPA

: E CARE - Green Network

Validity

: 01-10-2024 To 30-09-2025

Gender

: Female

Date Of Birth

: 14-Jan-1993

Patient's Tel No

: 0553635898

Service Date

: 21-Nov-2024

Health Provider

: CITICARE MEDICAL CENTER LLC

Doctor's Name

: Humaira

Co-Insurance

: CONSULTATION 10% max

Remarks

Network

: Green

Direct Access SP

: YES

LAB/RADIOLOGY	PHYSIO	PHARMACY	IP	MATERNITY	DENTAL
NIL	NIL	NIL LIMIT	NIL	10%	NA

☐ Acute

☐ Pre-existing and chronic

☐ Maternity

Chief Complaints

: co fever on and off sneezing dry cough 18th nov. 2024 oe chest is congested no added sounds restless

Duration:

Vitals

:Temp : 37 Bp :100 Pulse :86 Resp :18

Clinical Findings:

Diagnosis

: J06.9 - Acute upper respiratory infection, unspecified,J30.9 - Allergic rhinitis, unspecified,R50.9 - Fever, unspecified,R05 - Cough,K29.00 - Acute gastritis without bleeding,

Date of Onset

: 21/32/2024

Requested Investigations

: 85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,86140, C REACTIVE PROTEIN,0005-149902-1021, CLOFEN -(DICLOFENAC SODIUM : 75 MG/3ML) SOLUTION FOR INJECTION,0195-107704-0801, CEFTRIAXONE-TABUK IV,96365, THER/PROPH/DIAG IV INF INIT,96372, THER/PROPH/DIAG INJ SC/IM,0102-100104-1001, SODIUM CHLORIDE & DEXTROSE B.P.,96360, HYDRATION IV INFUSION INIT,0188-135906-2441, PULMICORT-(BUDESONIDE : 0.5 MG/ML) SUSPENSION FOR NEBULIZATION,94640, AIRWAY INHALATION TREATMENT,9, Consultation GP

Estimated : Cost

Prescriptions

: 6445-533801-1561 - (ESOMEPRAZOLE (AS MAGNESIUM : 20 MG DELAYED RELEASE CAPSULES,0005-116702-2481 - (DIPHENHYDRAMINE : 12.5 MG/5ML SYRUP (SUGAR FREE,0005-107001-0051 - (CAFFEINE : 65 MG) (PARACETAMOL : 500 MG) CAPLETS,0139-116206-1171 - (CLAVULANIC ACID : 125 MG) (AMOXICILLIN : 875 MG) 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}

21-Nov-2024

Signature

Date

: 21-Nov-2024

https://irhamc.visionsoftwares.ae/mr_ecare_claim_print.aspx?appId=55083&patId=31445

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