

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 :22-Nov-2024

Health Provider :CITICARE MEDICAL CENTER LLC

Doctor's Name :Humaira

Co-Insurance :

Remarks :

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 : Duration : :

Vitals:

Clinical Findings:

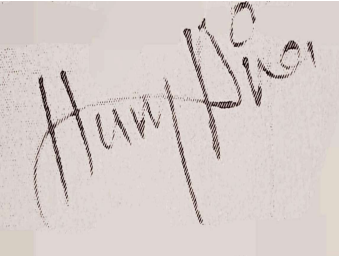
Diagnosis: J06.9 - Acute upper respiratory infection, unspecified,J30.9 - Allergic rhinitis, unspecified,R50.9 - Fever, unspecified,R05 - Cough,K29.00 - Acute gastritis without bleeding, Date of Onset :22/51/2024

Requested Investigations: 96365, THER/PROPH/DIAG IV INF INIT,0195-107704-0801, CEFTRIAXONE-TABUK IV,9.01, Follow Up Consultation GP Estimated Cost :

Prescriptions: 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 : Humaira

Signature : 

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.

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 : Nov-2024