Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	**: TEOPISTA NAMIREMBE**
Card No	**: I040-029-121406571-01**
Policy Holder	**: TEOPISTA NAMIREMBE**
Payer Name	**: UNION INSURANCE COMPANY**
TPA	**: E CARE - Blue Network**
Validity	**: 02-01-2025** To **01-01-2026**
Gender	**: Female**
Date Of Birth	**: 29-Nov-1993**
Patient's Tel No	**: 0563549408**

Service Date **:05-Jan-2025** **Network** **:** Green

Health Provider **:CITICARE MEDICAL CENTER LLC** **Direct Access SP - YES**

Doctor's Name **:Humaira**

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 : co fever on and off pain in throat running nose 1st jan. 2025 oe chest is congested no added sounds restless **Duration:**

Vitals: Temp : 36.9 Bp :128 Pulse :92 Resp :18

Clinical Findings:

Diagnosis: J06.9 - Acute upper respiratory infection, unspecified,J30.9 - Allergic rhinitis, unspecified,R50.9 - Fever, unspecified,K29.00 - Acute gastritis without bleeding,J00 - Acute nasopharyngitis [common cold], **Date of Onset** **:**05/52/2025

Requested Investigations: 85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,86140, C REACTIVE PROTEIN,0195-107704-0801, CEFTRIAXONE-TABUK IV,0005-149902-1021, CLOFEN -(DICLOFENAC SODIUM : 75 MG/3ML) SOLUTION FOR INJECTION,96365, THER/PROPH/DIAG IV INF INIT,96372, THER/PROPH/DIAG INJ SC/IM,0188-135906-2441, PULMICORT-(BUDESONIDE : 0.5 MG/ML) SUSPENSION FOR NEBULIZATION,94640, AIRWAY INHALATION TREATMENT,9, Consultation GP **Estimated Cost** **:**

Prescriptions: 0207-533801-1451 - (ESOMEPRAZOLE (AS MAGNESIUM : 20 MG CAPSULES (HARD GELATIN,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.

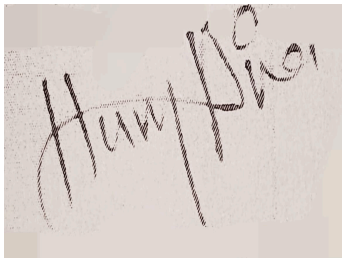
PATIENT'S DECLARATION :

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} **:** **Date :** 05-Jan-2025

Signature :  **Date** **:** 05-Jan-2025