Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	: **NINO MANALO . ORTEGA**	**Service Date**	:**11-Jan-2025** **Network** : Green
Card No	: **I040-029-119827244-01**	**Health Provider**	:**CITICARE MEDICAL CENTER LLC** **Direct Access SP - YES**
Policy Holder	: **NINO MANALO . ORTEGA**	**Doctor's Name**	:**SANDIA**
Payer Name	: **UNION INSURANCE COMPANY**	**Co-Insurance**	:
TPA	: **E CARE - Blue Network**	**Remarks**	:
Validity	: **02-01-2025** To **01-01-2026**		
Gender	: **Male**		
Date Of Birth	: **07-Aug-1997**		
Patient's Tel No	: **052671369**		

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 : cough which is dry , trouble breathing, myalgia fever for 3 days no other med conditions 0/e : pharynx hyperemia chest congested **Duration:**

Vitals: Temp : 37.4 Bp :130 Pulse :58 Resp :18

Clinical Findings:

Diagnosis: J06.9 - Acute upper respiratory infection, unspecified,R05 - Cough,R50.9 - Fever, unspecified, **Date of Onset :**11/17/2025

Requested Investigations: 85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,86140, C REACTIVE PROTEIN,2190-106618-1001, PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION,0195-107704-0801, CEFTRIAXONE-TABUK IV,0005-149902-1021, CLOFEN -(DICLOFENAC SODIUM : 75 MG/3ML) SOLUTION FOR INJECTION,96374, THER/PROPH/DIAG INJ IV PUSH,96365, THER/PROPH/DIAG IV INF INIT,96372, THER/PROPH/DIAG INJ SC/IM,9, Consultation GP **Estimated Cost :**

Prescriptions: 0837-277601-1161 - (OXOMEMAZINE : 0.33 MG/ML) SYRUP,0005-107001-0051 - (CAFFEINE : 65 MG (PARACETAMOL : 500 MG CAPLETS,0397-116207-0391 - (AMOXICILLIN : 500 MG (CLAVULANIC ACID : 125 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 : SANDIA **Stamp :**

Dr. Sandia Bhojwani
General Practitioner
DHA No: 65900212-001
PESHAWAR MEDICAL CENTER LLC
DUBAI - U.A.E.

Patient 's signature{Parent if minor} : **Date :** 11-Jan-2025

Signature : **Date** : 11-Jan-2025