Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	: **FETHI ACHI**	**Service Date**	:**22-Jan-2025**
Card No	: **I040-029-121180791-01**	**Health Provider**	:**CITICARE MEDICAL CENTER LLC**
Policy Holder	: **FETHI ACHI**	**Doctor's Name**	:**DR Amaizah**
Payer Name	: **UNION INSURANCE COMPANY**	**TPA**	: **E CARE - Blue Network**
Validity	: **02-01-2025** To **01-01-2026**	**Gender**	: **Male**
Date Of Birth	: **17-Nov-1999**	**Patient's Tel No**	: **0581127489**

Network : Green

Direct Access SP - YES

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 : soreness in throat persistant not improved with meds labs are normal known hypothyroidism on thyroxin **Duration:**

Vitals: Temp : 36 Bp :121 Pulse :98 Resp :18

Clinical Findings:

Diagnosis: E03.9 - Hypothyroidism, unspecified, **Date of Onset** : 22/12/2025

Requested Investigations: 9.01, Follow Up Consultation GP,0188-135906-2441, PULMICORT-(BUDESONIDE : 0.5 MG/ML) SUSPENSION FOR NEBULIZATION,94640, AIRWAY INHALATION TREATMENT **Estimated Cost** :

Prescriptions: 6705-602505-3801 - (HYDROXYPROPYLMETHYLCELLULOSE : 150 MG/ 30ML) SPRAY SOLUTION, **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 : DR Amaizah

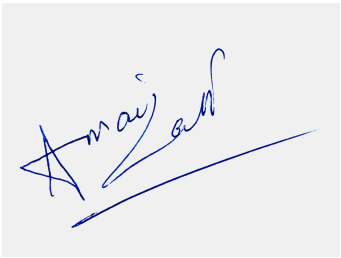
Stamp :

Dr. Amaizah Ishtiaq
General Practitioner
DHA: 98486553-001
CITICARE MEDICAL CENTER
DUBAI - U.A.E

Patient 's signature{Parent if minor} :

Date : 22-Jan-2025

Signature :



Date : 22-Jan-2025