

Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name : ALSE B
 Card No : I040-029-121984785-01
 Policy Holder : ALSE B

Payer Name : UNION INSURANCE COMPANY
 TPA : E CARE - Blue Network

Validity : 02-01-2025 To 01-01-2026

Gender : Female

Date Of Birth : 17-May-1986

Patient's Tel No : 971563093585

Service Date :26-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 nasal congestion productive cough 23rd jan. 2025 oe **Duration:** chest is congested no added sounds restless

Vitals:Temp : 36.9 Bp :140 Pulse :76 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,R03.0 - Elevated blood-pressure reading, w/o diagnosis of htn, **Date of Onset** :26/30/2025

Requested Investigations: 85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,86140, C REACTIVE PROTEIN,0188-135906-2441, PULMICORT-(BUDESONIDE : 0.5 MG/ML) SUSPENSION FOR NEBULIZATION,94640, AIRWAY INHALATION TREATMENT,9, Consultation GP **Estimated Cost** :

Prescriptions: 0005-116702-2481 - (DIPHENHYDRAMINE : 12.5 MG/5ML SYRUP (SUGAR FREE,0005-107001-0051 - (CAFFEINE : 65 MG) (PARACETAMOL : 500 MG) CAPLETS,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 :

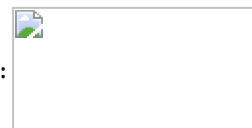
I hereby authorize any Healthcare provider, Insurer, Employer or other organization to release any information regarding my medical condition & history for purpose of determining insurance benefits.

Dr's Name : Humaira

Stamp :



Patient's signature{Parent : if minor}



Date : Jan-2025

Signature :

Date : 26-Jan-2025