Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	: **JEEVAN GAIRE**
Card No	: **I040-029-120758200-01**
Policy Holder	: **JEEVAN GAIRE**
Payer Name	: **UNION INSURANCE COMPANY**
TPA	: **E CARE - Blue Network**
Validity	: **02-01-2025** To **01-01-2026**
Gender	: **Male**
Date Of Birth	: **10-Oct-1996**
Patient's Tel No	: **0521627307**

Service Date :**05-Feb-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 : **Duration** :

Vitals: Temp : 36.4 Bp :140 Pulse :80 Resp :18

Clinical Findings:

Diagnosis: J06.9 - Acute upper respiratory infection, unspecified,J30.9 - Allergic rhinitis, unspecified,R05 - Cough,R50.9 - Fever, unspecified,K29.00 - Acute gastritis without bleeding, **Date of Onset** :05/22/2025

Requested Investigations: 0188-135906-2441, PULMICORT-(BUDESONIDE : 0.5 MG/ML) SUSPENSION FOR NEBULIZATION,94640, AIRWAY INHALATION TREATMENT,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.

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-Feb-2025

Signature :

Date : 05-Feb-2025