Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	**: KHALED MIAH**
Card No	**: I040-029-118643536-01**
Policy Holder	**: KHALED MIAH**
Payer Name	**: UNION INSURANCE COMPANY**
TPA	**: E CARE - Blue Network**
Validity	**: 02-01-2025** To **01-01-2026**
Gender	**: Male**
Date Of Birth	**: 20-Jan-2000**
Patient's Tel No	**: 0588334511**

Service Date **:10-Feb-2025** **Network** **:** Green

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

Doctor's Name **:DR Amaizah**

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 : 36.6 Bp :120 Pulse :74 Resp :21

Clinical Findings:

Diagnosis: R21 - Rash and other nonspecific skin eruption,I95.9 - Hypotension, unspecified, **Date of Onset** **:**10/30/2025

Requested Investigations: 0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE-(DEXAMETHASONE : 4 MG/ML) SOLUTION FOR INJECTION,96360, HYDRATION IV INFUSION INIT,0102-152902-1001, LACTATED RINGERS INJECTION USP,96372, THER/PROPH/DIAG INJ SC/IM,0102-111908-1001, SODIUM CHLORIDE B.P.,9.01, Follow Up Consultation GP **Estimated Cost** :

Prescriptions: **Estimated Cost** :

MEDICAL PRACTITIONER DECLARATION :

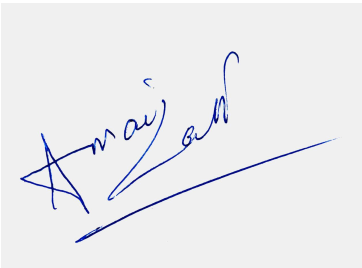
I declare that I am the patient's medical practitioner and that the particulars given are to the best of my knowledge true and correct.

Dr's Name : DR Amaizah

Stamp :

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

Signature :



Date : 10-Feb-2025

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.

Patient 's signature{Parent if minor} :

Date : 10-Feb-2025