

Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name

: MEGAN ELIZABETH

Card No

: I040-029-120344081-01

Policy Holder

: MEGAN ELIZABETH

Payer Name

: UNION INSURANCE COMPANY

TPA

: E CARE - Blue Network

Validity

: 05-02-2025 To 04-02-2026

Gender

: Male

Date Of Birth

: 11-Feb-1992

Patient's Tel No

: 05251192992

Service Date

:19-Feb-2025

Health Provider

:CITICARE MEDICAL CENTER LLC

Doctor's Name

:DR Amaizah

Co-Insurance

:

CONSULTATION	LAB/RADIOLOGY	PHYSIO	PHARMACY	IP	MATERNITY	DENTAL
10% max	NIL	NIL	NIL LIMIT	NIL	10%	NA

Network

: Green

Direct Access SP

- YES

☐ Acute

☐ Pre-existing and chronic

☐ Maternity

Chief Complaints

: PC : LOOSE STOOL 3 EPIDODES AFTER RETURNING FROM INDIA STARTED 13/02/25 NAUSEA WITHOUT VOMITTING STARTED 15/02/25 ABDOMINAL PAIN CRAMPING 15/02/25 EPIGASTRIC PAIN 15/02/25 O/E : LOOK LETHARGIC AND DEHYDRATED HYPERACTIVE BOWEL TENDER ABDOMEN

Duration:

Vitals

:Temp : 37 Bp :130 Pulse :84 Resp :18

Clinical Findings:

Diagnosis: K29.00 - Acute gastritis without bleeding,R50.9 - Fever, unspecified,R11.0 - Nausea,R52 - Pain, unspecified,E86.0 - Dehydration,

Date of Onset

:19/12/2025

Requested Investigations:

0102-152902-1001, LACTATED RINGERS INJECTION USP,96360, HYDRATION IV INFUSION INIT,0005-136504-1021, SCOPINAL-(HYOSCINE : 20 MG/ML) SOLUTION FOR INJECTION,0005-174202-0781, RISEK 40MG-(OMEPRAZOLE : 40 MG) POWDER FOR INFUSION,0195-107704-0801, CEFTRIAXONE-TABUK IV,87045, CUL BACT STOOL AEROBIC ISOL SALMONELLA&SHIGELLA,2190-106618-1001, PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION,96365, THER/PROPH/DIAG IV INF INIT,85025, BLOOD COUNT COMPLETE AUTO&AUTO DIRNTL WBC COUNT,86141, C TO REACTIVE PROTEIN HIGH SENSITIVITY,9, Consultation GP,96372, THER/PROPH/DIAG INJ SC/IM

Estimated Cost

:

Prescriptions:

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.

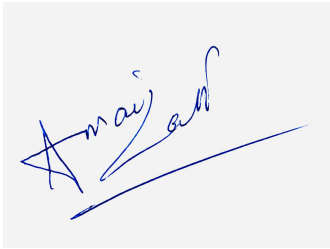
Dr's Name

: DR Amaizah

Stamp :

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

Signature :



Date : 19-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 : Feb-2025