Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	: **MEGAN ELIZABETH**	**Service Date**	:**19-Feb-2025** **Network** : Green
Card No	: **I040-029-120344081-01**	**Health Provider**	:**CITICARE MEDICAL CENTER LLC** **Direct Access SP - YES**
Policy Holder	: **MEGAN ELIZABETH**	**Doctor's Name**	:**DR Amaizah**
Payer Name	: **UNION INSURANCE COMPANY**	**Co-Insurance**	
TPA	: **E CARE - Blue Network**	**Remarks**	:
Validity	: **05-02-2025** To **04-02-2026**		
Gender	: **Male**		
Date Of Birth	: **11-Feb-1992**		
Patient's Tel No	: **05251192992**		

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

☐ **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 DIFRNTL WBC COUNT,86141, C TO REACTIVE PROTEIN HIGH SENSITIVITY,9, Consultation GP,96372, THER/PROPH/DIAG INJ SC/IM **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 : 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 :** 19-Feb-2025

Signature : **Date** : 19-Feb-2025