Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	**: arosha senal de**
Card No	**: I040-029-120327300-01**
Policy Holder	**: arosha senal de**
Payer Name	**: UNION INSURANCE COMPANY**
TPA	**: E CARE - Blue Network**
Validity	**: 02-01-2025** To **01-01-2026**
Gender	**: Male**
Date Of Birth	**: 09-Aug-2002**
Patient's Tel No	**: 0544580332**

Service Date **:19-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 : pc : pain in throat , sneezing , ruuny nose , wtaery eyes FEVER started 16/02/25 red eye , paINFUL DIFICULTY IN OPENING EYE IN MORNING STARTED 18/02/25 BP IS ELEVATED O/E : LOOK DEHYDRATED, LETHARGIC HYPRMIC PHARYNX, TONSILS RED ENLARGED REDISH CONUCTIVA , **Duration:**

Vitals: Temp : 37.1 Bp :130 Pulse :100 Resp :18

Clinical Findings:

Diagnosis: J02.9 - Acute pharyngitis, unspecified,J03.90 - Acute tonsillitis, unspecified,R50.9 - Fever, unspecified,J30.9 - Allergic rhinitis, unspecified,J45.991 - Cough variant asthma,E86.0 - Dehydration, **Date of Onset** **:**19/29/2025

Requested Investigations: 94640, AIRWAY INHALATION TREATMENT,0188-135906-2441, PULMICORT-(BUDESONIDE : 0.5 MG/ML) SUSPENSION FOR NEBULIZATION,85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,86140, C REACTIVE PROTEIN,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE-(DEXAMETHASONE : 4 MG/ML) SOLUTION FOR INJECTION,0195-107704-0801, CEFTRIAXONE-TABUK IV,96360, HYDRATION IV INFUSION INIT,0102-152902-1001, LACTATED RINGERS INJECTION USP,0005-149902-1021, CLOFEN ,96372, THER/PROPH/DIAG INJ SC/IM,96365, THER/PROPH/DIAG IV INF INIT,2190-106618-1001, PARAFUSIV,9, Consultation GP **Estimated Cost :**

Prescriptions: 0006-106601-0393 - (PARACETAMOL : 500 MG) FILM COATED TABLETS,0005-106802-0461 - (DEXTROMETHORPHAN : 30 MG) (PARACETAMOL : 650 MG) (PSEUDOEPHEDRINE : 60 MG) GRANULES FOR RECONSTITUTION,0085-232201-0371 - (NEPAFENAC : 0.1% EYE DROPS,0397-116207-0391 - (AMOXICILLIN : 500 MG (CLAVULANIC ACID : 125 MG FILM COATED TABLETS,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 : DR Amaizah

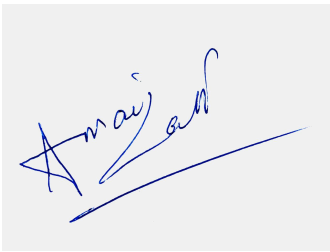
Stamp :

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