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 :21-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 : 37.1 Bp :130 Pulse :100 Resp :18

Clinical Findings:

Diagnosis: J30.9 - Allergic rhinitis, unspecified,J45.991 - Cough variant asthma,R21 - Rash and other nonspecific skin eruption,H10.13 - Acute atopic conjunctivitis, bilateral, **Date of Onset** :21/26/2025

Requested Investigations: 0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE-(DEXAMETHASONE : 4 MG/ML) SOLUTION FOR INJECTION,0005-111805-1021, CHLOROHISTOL 10MG-(CHLORPHENIRAMINE MALEATE : 10 MG/ML) SOLUTION FOR INJECTION,2190-106618-1001, PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION,0195-107704-0802, CEFTRIAXONE-TABUK IM,96372, THER/PROPH/DIAG INJ SC/IM,96365, THER/PROPH/DIAG IV INF INIT,9.01, Follow Up Consultation GP **Estimated Cost** :

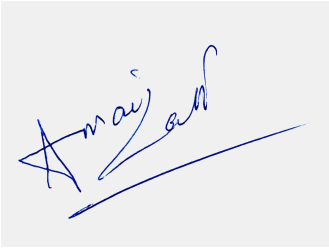
Prescriptions: 0252-389902-1172 - (LORATADINE : 5 MG) (PSEUDOEPHEDRINE SULPHATE : 120 MG) TABLETS,0005-119803-1173 - (PREDNISOLONE : 20 MG TABLETS, **Estimated Cost** :

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.

Dr's Name : DR Amaizah **Stamp :**

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

Signature :  **Date** : 21-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** : 21-Feb-2025