Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	**: JONATHAN MUJURIZI**
Card No	**: I040-029-122280431-01**
Policy Holder	**: JONATHAN MUJURIZI**
Payer Name	**: UNION INSURANCE COMPANY**
TPA	**: E CARE - Green Network**
Validity	**: 01-10-2024** To **30-09-2025**
Gender	**: Male**
Date Of Birth	**: 20-Mar-1996**
Patient's Tel No	**: 0581337571**

Service Date :**01-Mar-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 : epigastric pain associated with nause and vomitting started 28/02/25 **Duration:**
had 2 episoded of loose stool started 28/02/25 associate with low grade fever started 01/03/25
o/e : look pale lethargic dehydrated tender epigastric region

Vitals: Temp : 36.8 Bp :110 Pulse :84 Resp :18

Clinical Findings:

Diagnosis: K29.00 - Acute gastritis without bleeding,R11.2 - Nausea with vomiting, unspecified,E86.0 - Dehydration,R50.9 - Fever, unspecified,R52 - Pain, unspecified, **Date of Onset** :01/32/2025

Requested Investigations: 0102-152902-1001, LACTATED RINGERS INJECTION USP,0005-174202-0781, RISEK 40MG,0005-150403-1021, PREMOSAN -(METOCLOPRAMIDE : 10 MG/2ML) SOLUTION FOR INJECTION,96365, THER/PROPH/DIAG IV INF INIT,9, Consultation GP,96372, THER/PROPH/DIAG INJ SC/IM,96360, HYDRATION IV INFUSION INIT,2190-106618-1001, PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION,0005-136504-1021, SCOPINAL-(HYOSCINE : 20 MG/ML) SOLUTION FOR INJECTION,96360, HYDRATION IV INFUSION INIT,96374, THER/PROPH/DIAG INJ IV PUSH **Estimated Cost** :

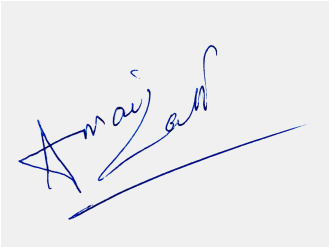
Prescriptions: **Estimated Cost** :

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** : 01-Mar-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 :** 01-Mar-2025