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 :**02-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 which is shrap in nature and severe on pain scale 7/10 associated with nause and vomitting started 28/02/25 had 2 episoded of loose stool started 28/02/25 associate with low grade fever started 01/03/25 flanks pain sharp , sudden onset , severe in intesity on pain scale its 7/10 radiating to back both sides with burning micturation and dysuria started 02/3/25 o/e : look pale lethargic dehydrated tender epigastric regio tender rt lft flanks

Duration:

Vitals:

Clinical Findings:

Diagnosis: R50.9 - Fever, unspecified,R11.2 - Nausea with vomiting, unspecified,E86.0 - Dehydration,K29.01 - Acute gastritis with bleeding,N39.0 - Urinary tract infection, site not specified,R52 - Pain, unspecified,

Date of Onset :02/29/2025

Requested Investigations: 81001, URNLS DIP STICK/TABLET REAGENT AUTO MICROSCOPY,0195-107704-0802, CEFTRIAXONE-TABUK IM,0005-136504-1021, SCOPINAL-(HYOSCINE : 20 MG/ML) SOLUTION FOR INJECTION,0005-150403-1021, PREMOSAN -(METOCLOPRAMIDE : 10 MG/2ML) SOLUTION FOR INJECTION,0005-149902-1021, CLOFEN ,0102-152902-1001, LACTATED RINGERS INJECTION USP,96360, HYDRATION IV INFUSION INIT,87338, IAAD EIA HPYLORI STOOL,9.01, Follow Up Consultation GP,96372, THER/PROPH/DIAG INJ SC/IM

Estimated Cost :

Prescriptions:

Estimated Cost :

MEDICAL PRACTITIONER DECLARATION :

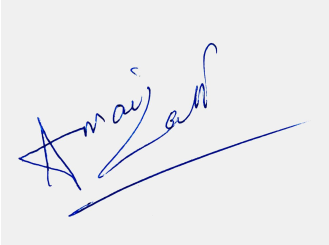
I declare that I am the patient's medical practitioner and that the particulars given are to the best of my knowledge true and correct.

Dr's Name : DR Amaizah

Stamp :

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

Signature :



Date : 02-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 : 02-Mar-2025