

Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name

EDSON FRANCIS
: FERNANDES EDWIN
FERNANDES

Card No

: I040-029-121777286-01

Policy Holder

EDSON FRANCIS
: FERNANDES EDWIN
FERNANDES

Payer Name

: UNION INSURANCE
COMPANY

TPA

: E CARE - Blue Network

Validity

: 13-01-2025 To 12-01-2026

Gender

: Male

Date Of Birth

: 19-Nov-2001

Patient's Tel No

: 0552037705

Service Date

:03-Mar-2025

Network

: Green

Health Provider

:CITICARE MEDICAL CENTER LLC

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 : EARACHE , SORETHROAT , DRY COUGH , ASSOCIATED WITH HIGH GRDE DURATION:
FEVER BODYPAIN , SHIVERING , BURNING IN EYES O/E : LOOK PALE , IRRITABLE DEHYDRATED
HYPEREMIC PHARYNX CHEST IS CONGESTED EAR CANAL . HEMATOMA

Vitals:Temp : 38 Bp :129 Pulse :86 Resp :18

Clinical Findings:

Diagnosis: J06.9 - Acute upper respiratory infection, unspecified,R50.9 - Fever, unspecified,J45.991 - Cough variant asthma,J30.9 - Allergic rhinitis, unspecified,H66.006 - Acute suppurative otitis media w/o spontaneous rupture of ear drum, recurrent, bilateral
Date of Onset :03/01/2025

Requested Investigations: 0195-107704-0801, CEFTRIAXONE-TABULAT IV,2190-106618-1001, PARAFUSION I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION,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,94640, AIRWAY INHALATION TREATMENT,0188-135906-2441, PULMICORT-(BUDESONIDE : 0.5 MG/ML) SUSPENSION FOR NEBULIZATION,96372, THER/PROPH/DIAG INJECTION/IM,96365, THER/PROPH/DIAG IV INITIATION,85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFFERENTIAL WBC COUNT,86140, C REACTIVE PROTEIN,9, Consultation GP,96374, THER/PROPH/DIAG INJECTION IV PUSH
Estimated Cost :

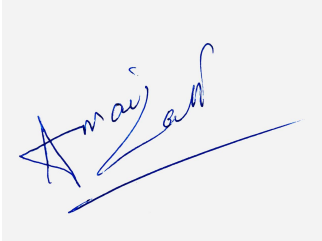
Prescriptions:

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 : 03-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 : Mar-2025