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

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 suppr otitis media w/o spon rupt ear drum, recur, bi, **Date of Onset** :03/01/2025

Requested Investigations: 0195-107704-0801, CEFTRIAXONE-TABUK IV,2190-106618-1001, PARAFUSIV 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 INJ SC/IM,96365, THER/PROPH/DIAG IV INF INIT,85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,86140, C REACTIVE PROTEIN,9, Consultation GP,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.

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** : 03-Mar-2025

Signature : **Date** : 03-Mar-2025