Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	: **JONATHAN MUJURIZI**	**Service Date**	:**03-Mar-2025** **Network** : Green
Card No	: **I040-029-122280431-01**	**Health Provider**	:**CITICARE MEDICAL CENTER LLC** **Direct Access SP - YES**
Policy Holder	: **JONATHAN MUJURIZI**	**Doctor's Name**	:**DR Amaizah**
Payer Name	: **UNION INSURANCE COMPANY**	**Co-Insurance**	:
TPA	: **E CARE - Green Network**	**Remarks**	:
Validity	: **01-10-2024** To **30-09-2025**		
Gender	: **Male**		
Date Of Birth	: **20-Mar-1996**		
Patient's Tel No	: **0581337571**		

CONSULTATION	LAB/RADIOLOGY	PHYSIO	PHARMACY	IP	MATERNITY	DENTAL
10% max	NIL	NIL	NIL LIMIT	NIL	10%	NA

☐ **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 27/02/25 had 2 episoded of loose stool started 27/02/25 associate with low grade fever started 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: K29.00 - Acute gastritis without bleeding,R11.2 - Nausea with vomiting, unspecified,E86.0 - Dehydration, **Date of Onset** :03/50/2025

Requested Investigations: 0102-152902-1001, LACTATED RINGERS INJECTION USP,0195-107704-0801, CEFTRIAXONE-TABUK IV,0005-150403-1021, PREMOSAN -(METOCLOPRAMIDE : 10 MG/2ML) SOLUTION FOR INJECTION,96365, THER/PROPH/DIAG IV INF INIT,96372, THER/PROPH/DIAG INJ SC/IM,96360, HYDRATION IV INFUSION INIT,9.01, Follow Up Consultation GP **Estimated Cost** :

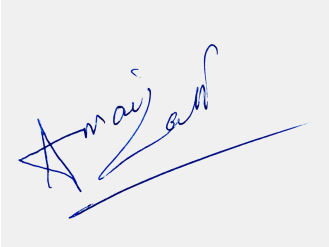
Prescriptions: **Estimated Cost** :

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** : 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 :** 03-Mar-2025