## Administrative MEDICAL CLAIM FORM Claim Ref:

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|---|---|---|---|
| **Patient Name** | **: EDSON FRANCIS FERNANDES EDWIN FERNANDES** | **Service Date** | **:05-Mar-2025** **Network** : Green |
| **Card No** | **: I040-029-121777286-01** | **Health Provider** | **:CITICARE MEDICAL CENTER LLC** **Direct Access SP - YES** |
| **Policy Holder** | **: EDSON FRANCIS FERNANDES EDWIN FERNANDES** | **Doctor's Name** | **:DR Amaizah** |
| **Payer Name** | **: UNION INSURANCE COMPANY** | **Co-Insurance** | : |
| **TPA** | **: E CARE - Blue Network** | **Remarks** | : |
| **Validity** | **: 13-01-2025** To **12-01-2026** | | |
| **Gender** | **: Male** | | |
| **Date Of Birth** | **: 19-Nov-2001** | | |
| **Patient's Tel No** | **: 0552037705** | | |

| 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 : 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 : 36.6 Bp :133 Pulse :86 Resp :18

**Clinical Findings:**

**Diagnosis:** J06.9 - Acute upper respiratory infection, unspecified,J45.991 - Cough variant asthma,J30.9 - Allergic rhinitis, unspecified,R50.9 - Fever, unspecified, **Date of Onset** :05/00/2025

**Requested Investigations:** 0195-107704-0802, CEFTRIAXONE-TABUK IM,2190-106618-1001, PARAFUSIV,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE,0005-111805-1021, CHLOROHISTOL 10MG-(CHLORPHENIRAMINE MALEATE : 10 MG/ML) SOLUTION FOR INJECTION,96372, THER/PROPH/DIAG INJ SC/IM,94640, AIRWAY INHALATION TREATMENT,0188-135906-2441, PULMICORT-(BUDESONIDE : 0.5 MG/ML) SUSPENSION FOR NEBULIZATION,96365, THER/PROPH/DIAG IV INF 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.

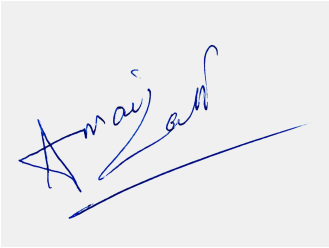
**PATIENT'S DECLARATION :**

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 :** 05-Mar-2025

**Signature :**  **Date** : 05-Mar-2025