Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	: **ANGELA WANGUI MAINA**	**Service Date**	:**12-Mar-2025** **Network** : Green
Card No	: **I040-029-120110893-01**	**Health Provider**	:**CITICARE MEDICAL CENTER LLC** **Direct Access SP - YES**
Policy Holder	: **ANGELA WANGUI MAINA**	**Doctor's Name**	:**DR Amaizah**
Payer Name	: **UNION INSURANCE COMPANY**	**Co-Insurance**	:
TPA	: **E CARE - Blue Network**	**Remarks**	:
Validity	: **02-01-2025** To **01-01-2026**		
Gender	: **Female**		
Date Of Birth	: **22-Feb-2002**		
Patient's Tel No	: **0553922018**		

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 : SORETHROAT , DYSPAHGIA , BODYPAIN , AND FEVER STARTED 10/03/25 **Duration:**
O/E : LOOK PALE LETHARGIC HYPEREMIC PHARYNX ENLARGED TONSILS WITH PUS POINT CHEST CONGESTED

Vitals: Temp : 36 Bp :120 Pulse :78 Resp :18

Clinical Findings:

Diagnosis: J03.91 - Acute recurrent tonsillitis, unspecified,R13.10 - Dysphagia, unspecified,R52 - Pain, unspecified,R50.9 - Fever, unspecified, **Date of Onset** :12/53/2025

Requested Investigations: 2190-106618-1001, PARAFUSIV,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE,0005-111805-1021, CHLOROHISTOL 10MG,0195-107704-0802, CEFTRIAXONE-TABUK IM,94640, AIRWAY INHALATION TREATMENT,0188-135906-2441, PULMICORT,96372, THER/PROPH/DIAG INJ SC/IM,85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,86140, C REACTIVE PROTEIN,96374, THER/PROPH/DIAG INJ IV PUSH,9, Consultation GP **Estimated Cost** :

Prescriptions: 6705-602505-3801 - (HYDROXYPROPYLMETHYLCELLULOSE : 150 MG/ 30ML) SPRAY SOLUTION,0005-119805-1172 - (PREDNISOLONE : 5 MG) TABLETS,0397-116207-0391 - (AMOXICILLIN : 500 MG (CLAVULANIC ACID : 125 MG FILM COATED TABLETS,0195-123701-0391 - (CETIRIZINE HCL : 10 MG) FILM COATED TABLETS, **Estimated Cost** :

MEDICAL PRACTITIONER DECLARATION :

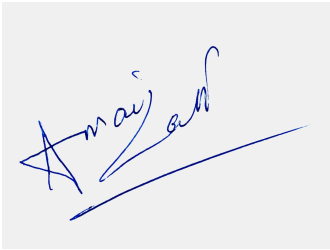
I declare that I am the patient's medical practitioner and that the particulars given are to the best of my knowledge true and correct.

Dr's Name : DR Amaizah

Stamp :

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

Signature :



Date : 12-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 : 12-Mar-2025