Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	: **ANGELA WANGUI MAINA**	**Service Date**	:**13-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**	:**Humaira**
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 : patient came yesterday with sore throat and bodyache done invetigation now she have high CRP and high eosnophils she have low blood pressure and signs of dehydrations like dry lips,sunken eyes,lethargy,cold extremitis **Duration:**

Vitals: Temp : 37.3 Bp :107 Pulse :72 Resp :0

Clinical Findings:

Diagnosis: J06.9 - Acute upper respiratory infection, unspecified,R03.1 - Nonspecific low blood-pressure reading,A49.9 - Bacterial infection, unspecified,E86.0 - Dehydration, **Date of Onset** :13/29/2025

Requested Investigations: 0195-107704-0801, CEFTRIAXONE-TABUK IV,0102-152902-1001, LACTATED RINGERS INJECTION USP,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE,96365, THER/PROPH/DIAG IV INF INIT,9.01, Follow Up Consultation GP,96360, HYDRATION IV INFUSION INIT,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 : Humaira

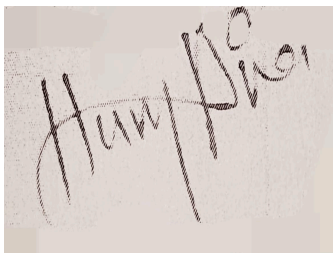
Stamp :

Dr. Humaira Mumtaz
General Practitioner
DHA No: 54155530-002
CITICARE MEDICAL CENTER LLC
DUBAI - U.A.E.

Patient 's signature{Parent if minor} :

Date : 13-Mar-2025

Signature :



Date : 13-Mar-2025