Administrative **MEDICAL CLAIM FORM** **Claim Ref:**

Patient Name	: **MOHAMMAD ETHISHAAM AHMAD JUNAID AHMAD**	**Service Date**	**:20-Mar-2025**
Card No	: **I040-029-113861887-01**	**Health Provider**	**:CITICARE MEDICAL CENTER LLC**
Policy Holder	: **MOHAMMAD ETHISHAAM AHMAD JUNAID AHMAD**	**Doctor's Name**	**:DR Amaizah**
Payer Name	: **UNION INSURANCE COMPANY**	**Co-Insurance**	:
TPA	: **ECARE-EBP EBP Enhanced CLASIC**	**Remarks**	:
Validity	: **13-01-2025** To **12-01-2026**		
Gender	: **Male**		
Date Of Birth	: **22-Nov-1997**		
Patient's Tel No	: **0542318198**		

Network : Green

Direct Access SP - YES

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 : SEVRE ABDOMINAL PAIN , VOMITTING , LOW GRADE FEVER , BODYPAIN BACKPAIN , SHIEVRING , FRONTAL HEADACHE STARTED 14/03/25 O/E : LOOK IRRITABLE , RESTLESS , DEHYDRATED SOFT BUT TENDER ABDOMEN **Duration:**

Vitals: Temp : 38 Bp :139 Pulse :64 Resp :18

Clinical Findings:

Diagnosis: R50.9 - Fever, unspecified,K29.00 - Acute gastritis without bleeding,A01.00 - Typhoid fever, unspecified,R11.2 - Nausea with vomiting, unspecified, **Date of Onset** :20/35/2025

Requested Investigations: 0195-107704-0801, CEFTRIAXONE-TABUK IV,2190-106618-1001, PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION,0102-152902-1001, LACTATED RINGERS INJECTION USP,96360, HYDRATION IV INFUSION INIT,0005-149902-1021, CLOFEN ,96372, THER/PROPH/DIAG INJ SC/IM,96365, THER/PROPH/DIAG IV INF INIT,0005-150403-1021, PREMOSAN -(METOCLOPRAMIDE : 10 MG/2ML) SOLUTION FOR INJECTION,9.01, Follow Up Consultation GP,96374, THER/PROPH/DIAG INJ IV PUSH,87045, CUL BACT STOOL AEROBIC ISOL SALMONELLA&SHIGELLA **Estimated Cost** :

Prescriptions: 3114-482003-0391 - (CIPROFLOXACIN (AS HYDROCHLORIDE) : 500 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.

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 : 20-Mar-2025

Signature :

Date : 20-Mar-2025