

Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name

: MOHAMMAD EHTISHAAM AHMAD JUNAID AHMAD

Card No

: 1040-029-113861887-01

Policy Holder

: MOHAMMAD EHTISHAAM AHMAD JUNAID AHMAD

Payer Name

: UNION INSURANCE COMPANY

TPA

: ECARE-EBP EBP Enhanced CLASIC

Validity

: 13-01-2025 To 12-01-2026

Gender

: Male

Date Of Birth

: 22-Nov-1997

Patient's Tel No

: 0542318198

Service Date

: 21-Mar-2025

Health Provider

: CITICARE MEDICAL CENTER LLC

Doctor's Name

: DR Amaizah

Co-Insurance

Network

: Green

Direct Access SP

: YES

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

Remarks

:

☐ Acute

☐ Pre-existing and chronic

☐ Maternity

Chief Complaints

: SEVERE 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 2ND DAY OF IV TRAETMENT CONDITION IMROVING NOW

Duration:

Vitals

:Temp : 36.4 Bp :140 Pulse :64 Resp :18

Clinical Findings:

Diagnosis

: K29.00 - Acute gastritis without bleeding,A01.00 - Typhoid fever, unspecified,R50.9 - Fever, unspecified,E78.2 - Mixed hyperlipidemia,I10 - Essential (primary) hypertension,

Date of Onset

: 21/01/2025

Requested Investigations

: 0195-107704-0801, CEFTRIAXONE-TABUK IV,0102-152902-1001, LACTATED RINGERS INJECTION USP,0005-150403-1021, PREMOSAN -(METOCLOPRAMIDE : 10 MG/2ML) SOLUTION FOR INJECTION,96360, HYDRATION IV INFUSION INIT,80061, LIPID PANEL,96372, THER/PROPH/DIAG INJ SC/IM,96365, THER/PROPH/DIAG IV INF INIT,2190-106618-1001, PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION

Estimated Cost

:

Prescriptions:

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.

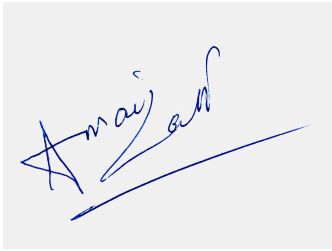
Dr's Name

: DR Amaizah

Stamp :

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

Signature :



Date

: 21-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

: 21-Mar-2025