Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	: **MOHAMMAD EHTISHAAM AHMAD JUNAID AHMAD**	**Service Date**	**:22-Mar-2025** **Network** : Green
Card No	: **I040-029-113861887-01**	**Health Provider**	**:CITICARE MEDICAL CENTER LLC** **Direct Access SP - YES**
Policy Holder	: **MOHAMMAD EHTISHAAM AHMAD JUNAID AHMAD**	**Doctor's Name**	**:Humaira**
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**		

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 : 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 : 36.8 Bp :120 Pulse :88 Resp :18

Clinical Findings:

Diagnosis: A49.9 - Bacterial infection, unspecified,R53.1 - Weakness, **Date of Onset** : 22/58/2025

Requested Investigations: 9.01, Follow Up Consultation GP,85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,86140, C REACTIVE PROTEIN,86768, ANTIBODY SALMONELLA,0195-107704-0801, CEFTRIAXONE-TABUK IV-(CEFTRIAXONE : 1 G) POWDER FOR INJECTION,0102-152902-1001, LACTATED RINGERS INJECTION USP,96365, THER/PROPH/DIAG IV INF INIT **Estimated Cost** :

Prescriptions: 0097-103201-0391 - (CIPROFLOXACIN : 500 MG) FILM COATED TABLETS,0219-533801-0392 - (ESOMEPRAZOLE (AS MAGNESIUM : 20 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.

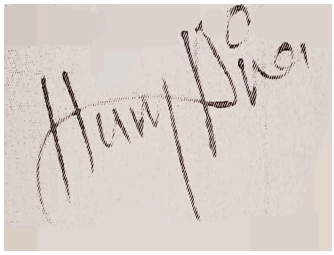
PATIENT'S DECLARATION :

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 : 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 :** 22-Mar-2025

Signature :  **Date** : 22-Mar-2025