

Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name

: SIYA DANSAN DANSAN VARGHESE

Card No

: I040-029-119450323-01

Policy Holder

: SIYA DANSAN DANSAN VARGHESE

Payer Name

: UNION INSURANCE COMPANY

TPA

: E CARE - Blue Network

Validity

: 02-01-2025 To 01-01-2026

Gender

: Female

Date Of Birth

: 19-Jan-1999

Patient's Tel No

: 0524408876

Service Date

:24-Mar-2025

Health Provider

:CITICARE MEDICAL CENTER LLC

Doctor's Name

:DR Amaizah

Co-Insurance

Remarks

:

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

: pc : earache , which is severe 8 on pain scale ., sorethroat , bodypain and high grade fever started 21/03/25 o/e : look lethargic irritable , pale and dehydrated ear canal full od secretions hyperemic pharynx tonsillar hypertrophy

Duration:

Vitals

:Temp : 36.4 Bp :120 Pulse :98 Resp :26

Clinical Findings:

Diagnosis:

J03.90 - Acute tonsillitis, unspecified,R50.9 - Fever, unspecified,H65.06 - Acute serous otitis media, recurrent, bilateral,D50.9 - Iron deficiency anemia, unspecified,

Date of Onset

:24/03/2025

Requested Investigations:

0195-107704-0801, CEFTRIAXONE-TABUK IV,0102-152902-1001, LACTATED RINGERS INJECTION USP,96360, HYDRATION IV INFUSION INIT,2190-106618-1001, PARAFUSIV,0248-122107-1021, DEXAMETHASONE SODIUM PHOSPHATE,85025, BLOOD COUNT COMPLETE AUTO&AUTO DIRNTL WBC COUNT,86140, C REACTIVE PROTEIN,96365, THER/PROPH/DIAG IV INF INIT,96372, THER/PROPH/DIAG INJ SC/IM,0005-149902-1021, CLOFEN ,96374, THER/PROPH/DIAG INJ IV PUSH,9, Consultation GP

Estimated : Cost

Prescriptions:

0252-182201-0081 - (FOLIC ACID : 0.35 MG) (IRON (AS FERRIC/FERROUS HYDROXIDE POLYMALTOSE COMPLEX) : 100 MG) CHEWABLE TABLETS,0005-119803-1171 - (PREDNISOLONE : 20 MG TABLETS,0397-116207-0391 - (AMOXICILLIN : 500 MG (CLAVULANIC ACID : 125 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

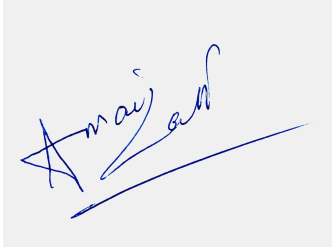
General Practitioner

DHA: 98486553-001

CITICARE MEDICAL CENTER

DUBAI - U.A.E

Signature :



Date

: 24-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

: 24-Mar-2025