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** **Network** : Green

Health Provider :**CITICARE MEDICAL CENTER LLC** **Direct Access SP - YES**

Doctor's Name :**DR Amaizah**

Co-Insurance :

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 : 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 tonsiller 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 DIFRNTL 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.

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** : 24-Mar-2025

Signature : **Date** : 24-Mar-2025