Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	: **SHUBHAM THAKAR SOM RAJ**	**Service Date**	:**25-Mar-2025** **Network** : Green
Card No	: **I040-029-121616018-01**	**Health Provider**	:**CITICARE MEDICAL CENTER LLC** **Direct Access SP - YES**
Policy Holder	: **SHUBHAM THAKAR SOM RAJ**	**Doctor's Name**	:**Humaira**
Payer Name	: **UNION INSURANCE COMPANY**	**Co-Insurance**	:
TPA	: **E CARE - Blue Network**	**Remarks**	:
Validity	: **02-01-2025** To **01-01-2026**		
Gender	: **Male**		
Date Of Birth	: **15-Jul-1996**		
Patient's Tel No	: **0529558657**		

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 : flu headache bodyache low back pain runny nose cough sore throat o/e hyperemia and chest pain **Duration:**

Vitals: Temp : 35.6 Bp :62 Pulse :74 Resp :0

Clinical Findings:

Diagnosis: J06.9 - Acute upper respiratory infection, unspecified,R05 - Cough,M54.5 - Low back pain, **Date of Onset** :25/40/2025

Requested Investigations: 9, Consultation GP,85027, BLOOD COUNT COMPLETE AUTOMATED,86140, C REACTIVE PROTEIN,0005-149902-1021, CLOFEN ,96372, THER/PROPH/DIAG INJ SC/IM,0188-135906-2441, PULMICORT,0195-107704-0801, CEFTRIAXONE-TABUK IV,0102-152902-1001, LACTATED RINGERS INJECTION USP,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE **Estimated Cost** :

Prescriptions: 0207-169703-1161 - (AMMONIUM CHLORIDE : N/A) (DIPHENHYDRAMINE : N/A) SYRUP,0031-149904-1171 - (DICLOFENAC SODIUM : 50 MG) TABLETS,0097-395404-0391 - (MONTELUKAST (AS SODIUM : 10 MG FILM COATED TABLETS,0006-106601-0392 - (PARACETAMOL : 500 MG) FILM COATED TABLETS,0097-127402-0391 - (AZITHROMYCIN : 250 MG) FILM COATED TABLETS,0320-148701-1171 - (LORATADINE : 10 MG) 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.

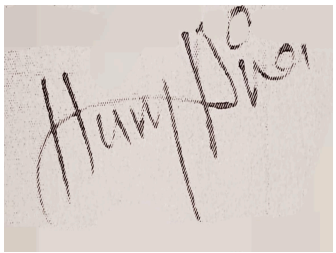
PATIENT'S DECLARATION :

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** : 25-Mar-2025

Signature :  **Date** : 25-Mar-2025