Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	**: BISHEK SIWA**
Card No	**: I040-029-121180790-01**
Policy Holder	**: BISHEK SIWA**
Payer Name	**: UNION INSURANCE COMPANY**
TPA	**: E CARE - Blue Network**
Validity	**: 02-01-2025** To **01-01-2026**
Gender	**: Male**
Date Of Birth	**: 07-Feb-1994**
Patient's Tel No	**: 0561557964**

Service Date **:08-Apr-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 : SORE THRAOT , COUGH WITH MUCOUS , FEVER STARTED 07/04/25 O/E : **Duration:**
LOOK LETHARGIC ,FEBLIRE HYPEREMIC PHARYNX CHEST CONGESRD

Vitals: Temp : 36.3 Bp :140 Pulse :110 Resp :18

Clinical Findings:

Diagnosis: J06.9 - Acute upper respiratory infection, unspecified,J45.991 - Cough variant asthma,R06.2 - Wheezing,R50.9 - Fever, unspecified, **Date of Onset** :08/59/2025

Requested Investigations: 0195-107704-0802, CEFTRIAXONE-TABUK IM,2190-106618-1001, PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION,94640, AIRWAY INHALATION TREATMENT,0006-402803-2071, VENTOLIN NEBULES,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE,85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,86140, C REACTIVE PROTEIN,96374, THER/PROPH/DIAG INJ IV PUSH,96365, THER/PROPH/DIAG IV INF INIT **Estimated Cost** :

Prescriptions: 0005-116801-1162 - (SODIUM CITRATE : 57 MG/5ML) (AMMONIUM CHLORIDE : 131.5 MG/5 ML) (MENTHOL : 1.1 MG/5 ML) (DIPHENHYDRAMINE : 13.5 MG/5ML) SYRUP,0397-116207-0391 - (AMOXICILLIN : 500 MG) (CLAVULANIC ACID : 125 MG) FILM COATED TABLETS,0195-123701-0391 - (CETIRIZINE HCL : 10 MG) FILM COATED TABLETS, **Estimated Cost** :

MEDICAL PRACTITIONER DECLARATION :

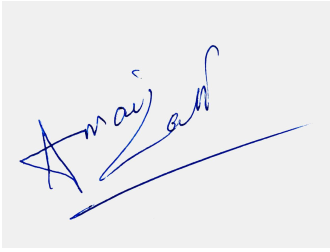
I declare that I am the patient's medical practitioner and that the particulars given are to the best of my knowledge true and correct.

Dr's Name : DR Amaizah

Stamp :

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

Signature :



Date : 08-Apr-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 : 08-Apr-2025