

Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name : MOHAMMAD EHTISHAAM AHMAD JUNAID AHMAD

Card No : I040-029-113861887-01

Policy Holder : MOHAMMAD EHTISHAAM AHMAD JUNAID AHMAD

Payer Name : UNION INSURANCE COMPANY

TPA : ECARE-EBP EBP Enhanced CLASIC

Validity : 13-01-2025 To 12-01-2026

Gender : Male

Date Of Birth : 22-Nov-1997

Patient's Tel No : 0542318198

Service Date :10-Apr-2025

Health Provider :CITICARE MEDICAL CENTER LLC

Doctor's Name :AISHA

Co-Insurance :

CONSULTATION	LAB/RADIOLOGY	PHYSIO	PHARMACY	IP	MATERNITY	DENTAL
10% max	NIL	NIL	NIL LIMIT	NIL	10%	NA

Remarks :

Network : Green

Direct Access SP - YES

☐ Acute

☐ Pre-existing and chronic

☐ Maternity

Chief Complaints : patient came with abdominal painful pain that radiates towards back along with vomiting and nausea since yesterday night of epigastric tenderness also right upper quadrant pain

Duration:

Vitals:Temp : 35.5 Bp :138 Pulse :49 Resp :18

Clinical Findings:

Diagnosis: K29.00 - Acute gastritis without bleeding,R11.2 - Nausea with vomiting, unspecified,K85.90 - Acute pancreatitis without necrosis or infection, unsp,R10.9 - Unspecified abdominal pain,R14.1 - Gas pain,

Date of Onset :10/03/2025

Requested Investigations: 85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFFERENTIAL WBC COUNT,86140, C REACTIVE PROTEIN,82150, AMYLASE,83690, LIPASE,0005-150403-1021, PREMOSON - (METOCLOPRAMIDE : 10 MG/2ML) SOLUTION FOR INJECTION,0005-174202-0781, RISEK 40MG- (OMEPRazole : 40 MG) POWDER FOR INFUSION,0005-136504-1021, SCOPINAL-(HYOSCINE : 20 MG/ML) SOLUTION FOR INJECTION,0439-152905-1001, LACTATED RINGERS INJECTION USP,9, Consultation GP,96365, THER/PROPH/DIAG IV INF INIT,96372, THER/PROPH/DIAG INJ SC/IM

Estimated : Cost

Prescriptions: 1516-151709-0081 - (SIMETHICONE : 42 MG) CHEWABLE TABLETS,0207-533801-1451 - (ESOMEPRazole (AS MAGNESIUM) : 20 MG) CAPSULES (HARD GELATIN),0097-397801-0391 - (DOMPERIDONE (AS MALEATE) : 10 MG) FILM COATED TABLETS,0042-136501-1171 - (HYOSCINE : 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.

Dr's Name : AISHA

Stamp :

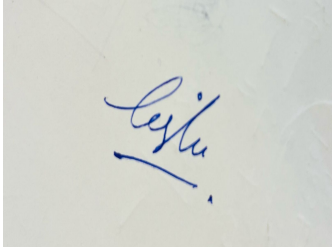
Dr. Aisha Umer

Physician- General Practitioner

DHA- 40131439-002

CITICARE MEDICAL CENTER

DUBAI - U.A.E

Signature :

Date : 10-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 : Apr-2025