

Administrative

Patient Name : NATHANIEL WELCOME

Card No : I040-029-118348457-01

Policy Holder : NATHANIEL WELCOME

Payer Name : UNION INSURANCE COMPANY

TPA : E CARE - Green Network

Validity : 01-10-2024 To 30-09-2025

Gender : Male

Date Of Birth : 12-Dec-1989

Patient's Tel No : 0569642461

MEDICAL CLAIM FORM

Service Date :15-Apr-2025

Health Provider :CITICARE MEDICAL CENTER LLC

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 :

Claim Ref:

Network : Green

Direct Access SP - YES

☐ Acute

☐ Pre-existing and chronic

☐ Maternity

Chief Complaints : pc : acid reflux . epigastric pain , burning , lower abdominal pain , flank pain ASSOCIATED WITH LOW GRADE FEVER o/e : look dehydrated and pale PREVIOUSLY URI AND URATE CRYSTALS ON URINE R E tendr flanks

Duration:

Vitals:

Clinical Findings:

Diagnosis: K29.00 - Acute gastritis without bleeding,N39.0 - Urinary tract infection, site not specified,R10.30 - Lower abdominal pain, unspecified,

Date of Onset :15/32/2025

Requested Investigations: 9, Consultation GP,96374, THER/PROPH/DIAG INJ IV PUSH,0195-107704-0801, CEFTRIAXONE-TABUK IV,96372, THER/PROPH/DIAG INJ SC/IM,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE,96360, HYDRATION IV INFUSION INIT,0005-174202-0781, RISEK 40MG,0439-152905-1001, LACTATED RINGERS INJECTION USP,84550, URIC ACID BLOOD,81002, URNLS DIP STICK/TABLET RGNT NON AUTO W/O MICRSCP,96365, THER/PROPH/DIAG IV INF INIT

Estimated Cost :

Prescriptions:

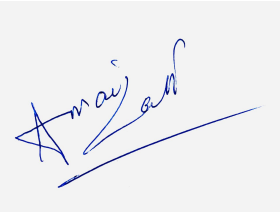
Estimated Cost :

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 : 15-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}



15-
Date : Apr-
2025

https://irhamc.visionsoftwares.ae/mr_ecare_claim_print.aspx?appld=61336&patId=39827

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