Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	: SANIA RASHEED	**Service Date**	:28-Apr-2025
Card No	: I040-029-120848630-01	**Health Provider**	:CITICARE MEDICAL CENTER LLC
Policy Holder	: SANIA RASHEED	**Doctor's Name**	:DR Amaizah
Payer Name	: UNION INSURANCE COMPANY	**Co-Insurance**	
TPA	: E CARE - Green Network	**Remarks**	:
Validity	: 01-10-2024 To 30-09-2025		
Gender	: Female		
Date Of Birth	: 20-Jan-1999		
Patient's Tel No	: 0558132736		

Network : Green

Direct Access SP - YES

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 : PC : SEVERE THROAT PAIN , BODYPAIN , DRY COUGH , HIGH GRADE FEVER STARTED 25/04/25 O/E : TONSILLS ARE SWOLLEN , WITH PUS POINTS HYPEREMIC PHARYNX **Duration:**

Vitals: Temp : 37.6 Bp :115 Pulse :93 Resp :18

Clinical Findings:

Diagnosis: J03.90 - Acute tonsillitis, unspecified,R50.9 - Fever, unspecified,R05 - Cough,R03.1 - Nonspecific low blood-pressure reading, **Date of Onset** :28/54/2025

Requested Investigations: 0439-152905-1001, LACTATED RINGERS INJECTION USP,2190-106618-1001, PARAFUSIV,96365, THER/PROPH/DIAG IV INF INIT,0195-107704-0802, CEFTRIAXONE-TABUK IM,96372, THER/PROPH/DIAG INJ SC/IM,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,9, Consultation GP,INJ064, VITAMIN D, INJECTION ,96372, INJECTION SERVICE-IM,96360, HYDRATION IV INFUSION INIT **Estimated Cost** :

Prescriptions: 6705-602505-3801 - (HYDROXYPROPYLMETHYLCELLULOSE : 150 MG/ 30ML) SPRAY SOLUTION,0118-114501-1161 - (AMBROXOL : 15 MG/5ML) SYRUP,2027-719101-0392 - (PARACETAMOL : 500 MG) (IBUPROFEN : 150 MG) (PHENYLEPHRINE HCL : 2.5 MG) FILM COATED 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

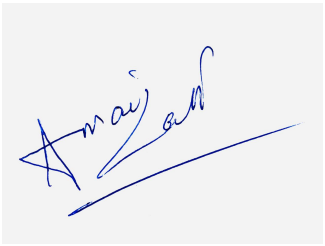
Stamp :

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

Patient 's signature{Parent if minor} :

Date : 28-Apr-2025

Signature :



Date : 28-Apr-2025