Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	**: JEEVAN GAIRE**
Card No	**: I040-029-120758200-01**
Policy Holder	**: JEEVAN GAIRE**
Payer Name	**: UNION INSURANCE COMPANY**
TPA	**: E CARE - Blue Network**
Validity	**: 02-01-2025** To **01-01-2026**
Gender	**: Male**
Date Of Birth	**: 10-Oct-1996**
Patient's Tel No	**: 0521627307**

Service Date **:28-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 : BURNING MICTURATION , DYSURIA AND STARTED FEW WEEKS AGO TAKING PAIN KILLER NOT IMPROVED O/E : LOOK PALE , LETHARGIC TENDER EPIGASTRIC AND HYPOGASTRIC **Duration:**

Vitals: Temp : 36.4 Bp :127 Pulse :80 Resp :18

Clinical Findings:

Diagnosis: R30.0 - Dysuria,N39.0 - Urinary tract infection, site not specified,R52 - Pain, unspecified,R34 - Anuria and oliguria, **Date of Onset** :28/26/2025

Requested Investigations: 81001, URNLS DIP STICK/TABLET REAGENT AUTO MICROSCOPY,80069, RENAL FUNCTION PANEL,0195-107704-0802, CEFTRIAXONE-TABUK IM,0439-152905-1001, LACTATED RINGERS INJECTION USP,96360, HYDRATION IV INFUSION INIT,85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,96365, THER/PROPH/DIAG IV INF INIT,0005-149902-1021, CLOFEN ,9, Consultation GP,96372, THER/PROPH/DIAG INJ SC/IM **Estimated Cost** :

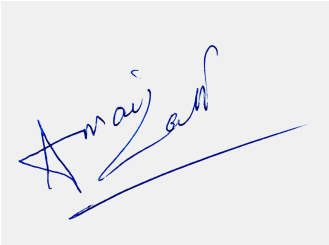
Prescriptions: **Estimated Cost** :

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** : 28-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 :** 28-Apr-2025