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 :**29-Apr-2025** **Network** : Green

Health Provider :**CITICARE MEDICAL CENTER LLC** **Direct Access SP - YES**

Doctor's Name :**Dr.Farhan Iyas**

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 : came for follow up on investigation there is very high leukocytes and erythrocytes in the urine **Duration:**

Vitals: Temp : 36.4 Bp :105 Pulse :80 Resp :18

Clinical Findings:

Diagnosis: N39.0 - Urinary tract infection, site not specified,R30.9 - Painful micturition, unspecified,R52 - Pain, unspecified,A49.9 - Bacterial infection, unspecified, **Date of Onset** :29/17/2025

Requested Investigations: 0195-107704-0801, CEFTRIAXONE-TABUK IV,0439-152905-1001, LACTATED RINGERS INJECTION USP,96365, THER/PROPH/DIAG IV INF INIT,0005-149902-1021, CLOFEN ,96372, THER/PROPH/DIAG INJ SC/IM,9.01, Follow Up Consultation GP,96360, HYDRATION IV INFUSION INIT **Estimated Cost** :

Prescriptions: 0152-116604-0391 - (METRONIDAZOLE : 500 MG) FILM COATED TABLETS,4884-622202-1171 - (SERRAPEPTASE : 10 MG) TABLETS,6619-548302-0251 - (SODIUM BICARBONATE : 1.76G) (SODIUM CITRATE ANHYDROUS : 0.63G) (TARTARIC ACID : 0.89G) (CITRIC ACID ANHYDROUS : 0.715 G) EFFERVESCENT GRANULES,0097-103202-0391 - (CIPROFLOXACIN : 250 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.

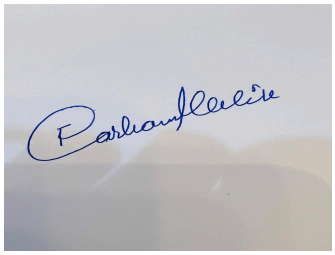
PATIENT'S DECLARATION :

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.Farhan Iyas **Stamp :**

Dr .Frahan Ilyas Malik
Physician-General Practitioner
DHA-06441782-001
CITICARE MEDICAL CENTER
DUBAI U.A.E

Patient 's signature{Parent : if minor} **Date :** 29-Apr-2025

Signature :  **Date** : 29-Apr-2025