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 :**30-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 : came for follow up on investigation there is very high leukocytes and erythrocytes in the urine BURNING MICTURATION , DYSURIA AND STARTED FEW WEEKS AGO penile dischrge which is foul smelling TAKING PAIN KILLER NOT IMPROVED O/E : LOOK PALE , LETHARGIC TENDER EPIGASTRIC AND HYPOGASTRIC **Duration:**

Vitals:

Clinical Findings:

Diagnosis: N39.0 - Urinary tract infection, site not specified,R30.0 - Dysuria,R36.9 - Urethral discharge, unspecified,N30.01 - Acute cystitis with hematuria,N10 - Acute pyelonephritis, **Date of Onset** :30/56/2025

Requested Investigations: 0195-107704-0802, CEFTRIAXONE-TABUK IM,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE,0005-136504-1021, SCOPINAL,96360, HYDRATION IV INFUSION INIT,0439-152905-1001, LACTATED RINGERS INJECTION USP,0002-116601-1001, METRONIDAZOLE : 500 MG/100ML) SOLUTION FOR INFUSION ,96372, THER/PROPH/DIAG INJ SC/IM **Estimated Cost** :

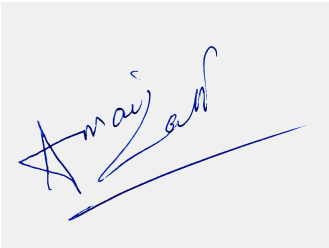
Prescriptions: **Estimated Cost** :

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** : 30-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** : 30-Apr-2025