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 :01-May-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 : me 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: R30.0 - Dysuria,N39.0 - Urinary tract infection, site not specified,N30.91 - Cystitis, unspecified with hematuria,N10 - Acute pyelonephritis,R50.9 - Fever, unspecified,E86.0 - Dehydration, **Date of Onset** :01/47/2025

Requested Investigations: 0195-107704-0801, CEFTRIAXONE-TABUK IV,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE,0005-136504-1021, SCOPINAL,0002-116601-1001, METRONIDAZOLE : 500 MG/100ML) SOLUTION FOR INFUSION ,96372, THER/PROPH/DIAG INJ SC/IM,96365, THER/PROPH/DIAG IV INF INIT **Estimated Cost** :

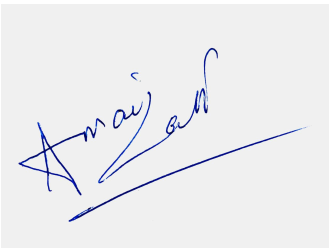
Prescriptions: **Estimated Cost** :

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** : 01-May-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** : 01-May-2025