Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	: HTOO THINZAR	**Service Date**	:02-May-2025
Card No	: I040-029-117339604-01	**Health Provider**	:CITICARE MEDICAL CENTER LLC
Policy Holder	: HTOO THINZAR	**Doctor's Name**	:AISHA
Payer Name	: UNION INSURANCE COMPANY	**Co-Insurance**	
TPA	: E CARE - Blue Network	**Remarks**	:
Validity	: 13-01-2025 To 12-01-2026		
Gender	: Female		
Date Of Birth	: 06-Jul-1996		
Patient's Tel No	: 0585292639		

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 : pt came with generalise weakness since morning she complain of vertigo ,body pain ,fever high blood pressure **Duration:**

Vitals: Temp : 37.3 Bp :139 Pulse :99 Resp :0

Clinical Findings:

Diagnosis: R53.1 - Weakness,R50.9 - Fever, unspecified,E16.2 - Hypoglycemia, unspecified,I10 - Essential (primary) hypertension,R52 - Pain, unspecified, **Date of Onset** :02/10/2025

Requested Investigations: 0005-149902-1021, CLOFEN -(DICLOFENAC SODIUM : 75 MG/3ML) SOLUTION FOR INJECTION,2190-106618-1001, PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION,96372, THER/PROPH/DIAG INJ SC/IM,96365, THER/PROPH/DIAG IV INF INIT,Pa001, COMPLETE WELLNESS CHECKUP,9, Consultation GP,Pa001, COMPLETE WELLNESS CHECKUP **Estimated Cost** :

Prescriptions: 0006-106601-0394 - (PARACETAMOL : 500 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 : AISHA **Stamp :**

Dr. Aisha Umer
Physician- General Practitioner
DHA- 40131439-002
CITICARE MEDICAL CENTER
DUBAI - U.A.E

Patient 's signature{Parent if minor} : **Date** : 02-May-2025

Signature : **Date** : 02-May-2025