Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	**: SANGIMA . RAI**
Card No	**: I040-029-120328025-01**
Policy Holder	**: SANGIMA . RAI**
Payer Name	**: UNION INSURANCE COMPANY**
TPA	**: E CARE - Blue Network**
Validity	**: 02-01-2025** To **01-01-2026**
Gender	**: Female**
Date Of Birth	**: 20-Dec-2003**
Patient's Tel No	**: 0566492355**

Service Date **:02-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 : PC : SEVRE RASH ON FACE AND BODY ASSOCIATED WITH FEVER , BODYPAIN , **Duration:** WEAKNESS AND SORE THROAT STARTED 01/05/25 O/E FLUID FILLED VESICLES RED BASE HYPEREMIC PHARYNX

Vitals: Temp : 37.4 Bp :110 Pulse :92 Resp :18

Clinical Findings:

Diagnosis: R21 - Rash and other nonspecific skin eruption,R50.9 - Fever, unspecified,R52 - Pain, unspecified,J02.9 - Acute pharyngitis, unspecified,B01.9 - Varicella without complication, **Date of Onset** **:**02/50/2025

Requested Investigations: 0439-152905-1001, LACTATED RINGERS INJECTION USP,2190-106618-1001, PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION,0005-149902-1021, CLOFEN ,0005-111805-1021, CHLOROHISTOL 10MG,96372, THER/PROPH/DIAG INJ SC/IM,0195-107704-0801, CEFTRIAXONE-TABUK IV,85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,86140, C REACTIVE PROTEIN,INJ014, INJ-NEUROBION VITAMIN B GROUPS,11GA01, VITAMIN - C- IV DRIP,96360, HYDRATION IV INFUSION INIT,9, Consultation GP,96365, THER/PROPH/DIAG IV INF INIT,96374, THER/PROPH/DIAG INJ IV PUSH **Estimated Cost** :

Prescriptions: 2027-719101-0391 - (PARACETAMOL : 500 MG) (IBUPROFEN : 150 MG) (PHENYLEPHRINE HCL : 2.5 MG) FILM COATED TABLETS,0880-609601-0571 - (CALAMINE : 15 G/100ML) (ZINC OXIDE : 5 G/100ML) (PHENOL : 0.5 G/100ML) (BENTONITE : 3 G/100ML) LOTION,0195-123701-0391 - (CETIRIZINE HCL : 10 MG) FILM COATED TABLETS,0015-102402-1172 - (ACYCLOVIR : 400 MG) 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 Amaizah

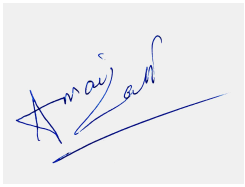
Stamp :

Dr. Amaizah Ishtiaq
General Practitioner
DHA: 98486553-001
CITICARE MEDICAL CENTER
DUBAI - U.A.E

Patient 's signature{Parent if minor} :

Date : 02-May-2025

Signature :



Date : 02-May-2025