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 **: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 : Follow up FOR CONTINOUS PARENTERAL TREATMENT FOR ACUTE PYELONEPHRITIS AND ASCENDING URINARY TRACT INFECTION CAUSING URINARY SYMPTOMS 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: Temp : 36.7 Bp :120 Pulse :78 Resp :18

Clinical Findings:

Diagnosis: R30.0 - Dysuria,N39.0 - Urinary tract infection, site not specified,R52 - Pain, unspecified,N30.01 - Acute cystitis with hematuria,E86.0 - Dehydration, **Date of Onset** :02/41/2025

Requested Investigations: 0195-107704-0801, CEFTRIAXONE-TABUK IV,96365, THER/PROPH/DIAG IV INF INIT,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE,INJ060, INJ-METRONIDAZOLE 500 MG/100ML - IV,96372, THER/PROPH/DIAG INJ SC/IM,9.01, Follow Up Consultation GP **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.

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