Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	: **DEEPAK KUMAR . RAVEENDRA**	**Service Date**	**:04-May-2025**
Card No	: **I040-029-120358979-01**	**Health Provider**	**:CITICARE MEDICAL CENTER LLC**
Policy Holder	: **DEEPAK KUMAR . RAVEENDRA**	**Doctor's Name**	**:DR Amaizah**
Payer Name	: **UNION INSURANCE COMPANY**	**Co-Insurance**	:
TPA	: **E CARE - Blue Network**	**Remarks**	:
Validity	: **02-01-2025** To **01-01-2026**		
Gender	: **Male**		
Date Of Birth	: **08-Jan-1986**		
Patient's Tel No	: **0547325221**		

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 : PC : FLANK PAIN AND GENERALIZED ABDOMINAL PAIN , FEELONG TIRED LETHARGIC , BURNING MICTURATION HE DRINKS ALCOHOL O/E : ABDOMEN DISTENDED **Duration:**

Vitals: Temp : 35.6 Bp :122 Pulse :65 Resp :18

Clinical Findings:

Diagnosis: R10.12 - Left upper quadrant pain,R10.84 - Generalized abdominal pain,R30.0 - Dysuria,N39.0 - Urinary tract infection, site not specified, **Date of Onset** :04/35/2025

Requested Investigations: 81001, URNLS DIP STICK/TABLET REAGENT AUTO MICROSCOPY,80069, RENAL FUNCTION PANEL,85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,9, Consultation GP **Estimated Cost** :

Prescriptions: **Estimated Cost** :

MEDICAL PRACTITIONER DECLARATION :

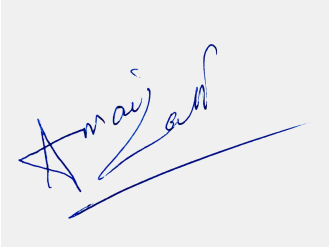
I declare that I am the patient's medical practitioner and that the particulars given are to the best of my knowledge true and correct.

Dr's Name : DR Amaizah

Stamp :

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

Signature :



Date : 04-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 : 04-May-2025