Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	: **ANITA MAGAR DHANJIT MAGAR**	**Service Date**	:**09-May-2025** **Network** : Green
Card No	: **I040-029-119014964-01**	**Health Provider**	:**CITICARE MEDICAL CENTER LLC** **Direct Access SP - YES**
Policy Holder	: **ANITA MAGAR DHANJIT MAGAR**	**Doctor's Name**	:**DR Amaizah**
Payer Name	: **UNION INSURANCE COMPANY**	**Co-Insurance**	:
TPA	: **E CARE - Green Network**	**Remarks**	:
Validity	: **01-10-2024** To **30-09-2025**		
Gender	: **Female**		
Date Of Birth	: **20-Oct-1996**		
Patient's Tel No	: **0544398628**		

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 : sore throat , body pain , which is sevre 8 on pain scale sneezing , nasal congestion strated 08/05/25 tok panadol not improved oral intake is reduced due to difficulty in swallowing o/e : look pale , lethargic , hyperemic pharynx chest congested low blood pressure **Duration:**

Vitals: Temp : 36.6 Bp :118 Pulse :76 Resp :18

Clinical Findings:

Diagnosis: J02.9 - Acute pharyngitis, unspecified,R50.9 - Fever, unspecified,R06.2 - Wheezing,M54.5 - Low back pain, **Date of Onset** :09/52/2025

Requested Investigations: 85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,86140, C REACTIVE PROTEIN,0195-107704-0801, CEFTRIAXONE-TABUK IV,2190-106618-1001, PARAFUSIV,0005-149902-1021, CLOFEN ,0439-152905-1001, LACTATED RINGERS INJECTION USP,96360, HYDRATION IV INFUSION INIT,96372, THER/PROPH/DIAG INJ SC/IM,9, Consultation GP,96374, THER/PROPH/DIAG INJ IV PUSH,96365, THER/PROPH/DIAG IV INF INIT **Estimated Cost** :

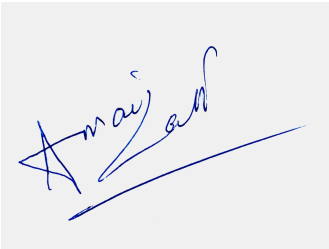
Prescriptions: 2027-719101-0391 - (PARACETAMOL : 500 MG) (IBUPROFEN : 150 MG) (PHENYLEPHRINE HCL : 2.5 MG) FILM COATED TABLETS,0027-149906-1171 - (DICLOFENAC SODIUM : 25 MG) TABLETS,0397-116207-0391 - (AMOXICILLIN : 500 MG) (CLAVULANIC ACID : 125 MG) FILM COATED TABLETS, **Estimated Cost** :

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.

Dr's Name : DR Amaizah **Stamp :**

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

Signature :  **Date** : 09-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** : 09-May-2025