# Administrative MEDICAL CLAIM FORM Claim Ref:

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|---|---|---|---|
| **Patient Name** | : **SIDDHI PRAKASH VAITY PRAKASH MAHADEO VAITY** | **Service Date** | **:13-May-2025** **Network** : Green |
| **Card No** | : **I040-029-122430605-01** | **Health Provider** | **:CITICARE MEDICAL CENTER LLC** **Direct Access SP - YES** |
| **Policy Holder** | : **SIDDHI PRAKASH VAITY PRAKASH MAHADEO VAITY** | **Doctor's Name** | **:DR Amaizah** |
| **Payer Name** | : **UNION INSURANCE COMPANY** | **Co-Insurance** | : |
| **TPA** | : **E CARE - Green Network** | | |
| **Validity** | : **27-03-2025** To **30-09-2025** | **Remarks** | : |
| **Gender** | : **Female** | | |
| **Date Of Birth** | : **25-May-1997** | | |
| **Patient's Tel No** | : **0524517821** | | |

| 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 : KNOWN HYPERTHYROIDISM ON MEDICATIONS COMPLEATED MEDICATION COURSE FOR 3 MONTHS , PRESENTE WITH LETHARGY , REDUCED APPETITE ,AND LOWER ABDOMINAL PAIN , DYSMENORRHEA AND DIZINESS , STATED 10/05/25 O/E : LOOK PLAE , LETHARGIC TENDER HYPOGASTRIC LOW BLOOD PRESSURE **Duration:**

**Vitals:**Temp : 36 Bp :90 Pulse :84 Resp :18

**Clinical Findings:**

**Diagnosis:** E03.9 - Hypothyroidism, unspecified,R03.1 - Nonspecific low blood-pressure reading,R10.30 - Lower abdominal pain, unspecified,E86.0 - Dehydration,D50.9 - Iron deficiency anemia, unspecified, **Date of Onset** :13/59/2025

**Requested Investigations:** 84443, THYROID STIMULATING HORMONE TSH,85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,0439-152905-1001, LACTATED RINGERS INJECTION USP,0005-136504-1021, SCOPINAL,96360, HYDRATION IV INFUSION INIT,2190-106618-1001, PARAFUSIV,INJ064, VITAMIN D, INJECTION ,97010, SPECIAL SUPPLIES,96372, INJECTION SERVICE-IM,9, Consultation GP,96374, THER/PROPH/DIAG INJ IV PUSH,96372, THER/PROPH/DIAG INJ SC/IM **Estimated Cost** :

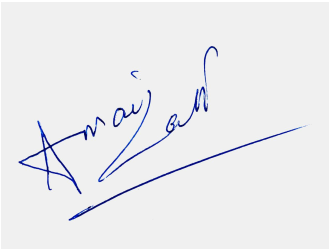
**Prescriptions:** **Estimated Cost** :

**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** : 13-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** : 13-May-2025