Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	**: ADEEL ASHRAF**
Card No	**: I040-029-119910860-01**
Policy Holder	**: ADEEL ASHRAF**
Payer Name	**: UNION INSURANCE COMPANY**
TPA	**: E CARE-Medium- Gold and Silver**
Validity	**: 13-01-2025** To **12-01-2026**
Gender	**: Male**
Date Of Birth	**: 03-Sep-1990**
Patient's Tel No	**: 0543702807**

Service Date **:17-May-2025** **Network** : Green

Health Provider **:CITICARE MEDICAL CENTER LLC** **Direct Access SP - YES**

Doctor's Name **:Dr.Farhan Iyas**

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 : sore throat severe body pain nasal congestion low back pain **Duration :**

Vitals: Temp : 37.1 Bp :140 Pulse :96 Resp :18

Clinical Findings:

Diagnosis: J02.9 - Acute pharyngitis, unspecified,R50.9 - Fever, unspecified,M54.5 - Low back pain,R09.81 - Nasal congestion, **Date of Onset** :17/02/2025

Requested Investigations: 85004, BLOOD COUNT AUTOMATED DIFFERENTIAL WBC COUNT,86140, C REACTIVE PROTEIN,2190-106618-1001, PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION,96374, THER/PROPH/DIAG INJ IV PUSH,0188-135906-2441, PULMICORT,94640, AIRWAY INHALATION TREATMENT,9, Consultation GP,96365, THER/PROPH/DIAG IV INF INIT **Estimated Cost** :

Prescriptions: 0097-142201-0391 - (DICLOFENAC POTASSIUM : 50 MG) FILM COATED TABLETS,0397-116207-0391 - (AMOXICILLIN : 500 MG) (CLAVULANIC ACID : 125 MG) FILM COATED TABLETS,0320-148701-1171 - (LORATADINE : 10 MG) TABLETS,0006-106601-0393 - (PARACETAMOL : 500 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.

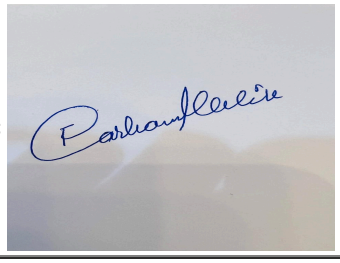
PATIENT'S DECLARATION :

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.Farhan Iyas **Stamp :**

Dr .Frahan Ilyas Malik
Physician-General Practitioner
DHA-06441782-001
CITICARE MEDICAL CENTER
DUBAI U.A.E

Patient 's signature{Parent if minor} : **Date** : 17-May-2025

Signature :  **Date** : 17-May-2025