Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	: **SAMIR ELSAYED MOHAMED ALI GOMAA**	**Service Date**	:**26-May-2025** **Network** : Green
Card No	: **I040-029-121565065-01**	**Health Provider**	:**CITICARE MEDICAL CENTER LLC** **Direct Access SP - YES**
Policy Holder	: **SAMIR ELSAYED MOHAMED ALI GOMAA**	**Doctor's Name**	:**AISHA**
Payer Name	: **UNION INSURANCE COMPANY**	**Co-Insurance**	:
TPA	: **E CARE - Green Network**	**Remarks**	:
Validity	: **01-10-2024** To **30-09-2025**		
Gender	: **Male**		
Date Of Birth	: **17-Sep-1988**		
Patient's Tel No	: **0528156822**		

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 : pt came with severe burning pain in urine started this morning when ho void last time he feels that there is blockage in package **Duration:**

Vitals: Temp : 36.6 Bp :108 Pulse :75 Resp :18

Clinical Findings:

Diagnosis: N39.0 - Urinary tract infection, site not specified,R30.0 - Dysuria,R30.9 - Painful micturition, unspecified,E86.0 - Dehydration, **Date of Onset** :26/02/2025

Requested Investigations: 86140, C REACTIVE PROTEIN,80069, RENAL FUNCTION PANEL,0102-100104-1001, SODIUM CHLORIDE & DEXTROSE B.P.,0195-107704-0801, CEFTRIAXONE-TABUK IV,0005-136504-1021, SCOPINAL,96372, THER/PROPH/DIAG INJ SC/IM,96374, THER/PROPH/DIAG INJ IV PUSH,96360, HYDRATION IV INFUSION INIT,9, Consultation GP **Estimated Cost** :

Prescriptions: 2803-238401-0061 - (TAMSULOSIN HCL : 0.4 MG) CAPSULES,6619-548302-0251 - (SODIUM BICARBONATE : 1.76G) (SODIUM CITRATE ANHYDROUS : 0.63G) (TARTARIC ACID : 0.89G) (CITRIC ACID ANHYDROUS : 0.715 G) EFFERVESCENT GRANULES,3114-482003-0391 - (CIPROFLOXACIN (AS HYDROCHLORIDE) : 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 : AISHA

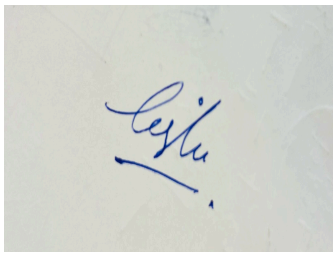
Stamp :

Dr. Aisha Umer
Physician- General Practitioner
DHA- 40131439-002
CITICARE MEDICAL CENTER
DUBAI - U.A.E

Patient 's signature{Parent : if minor}

Date : 26-May-2025

Signature :



Date : 26-May-2025