Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	: **RANA MUHAMMAD ABID RIZWAN MUHAMMAD RAMZAN**	**Service Date**	**:26-May-2025**
Card No	: **I040-029-119491020-01**	**Health Provider**	**:CITICARE MEDICAL CENTER LLC**
Policy Holder	: **RANA MUHAMMAD ABID RIZWAN MUHAMMAD RAMZAN**	**Doctor's Name**	**:DR Amaizah**
Payer Name	: **UNION INSURANCE COMPANY**	**Co-Insurance**	:
TPA	: **E CARE - Blue Network**	**Remarks**	:
Validity	: **13-01-2025** To **12-01-2026**		
Gender	: **Male**		
Date Of Birth	: **10-Oct-1986**		
Patient's Tel No	: **0509212820**		

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 : sore throat , sneezing , odynophagia , severe bodypain 08 on pain scale ,reduced appetite , high grade fever started 24/05/25 took panadol not improved o/e : look pale , dehydrated tonsills are swollen and pus points chest wheezing **Duration:**

Vitals: Temp : 37.9 Bp :118 Pulse :86 Resp :18

Clinical Findings:

Diagnosis: J03.91 - Acute recurrent tonsillitis, unspecified,R52 - Pain, unspecified,R50.9 - Fever, unspecified,R06.2 - Wheezing,E86.0 - Dehydration, **Date of Onset** :26/55/2025

Requested Investigations: 0195-107704-0801, CEFTRIAXONE-TABUK IV,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE,0005-149902-1021, CLOFEN -(DICLOFENAC SODIUM : 75 MG/3ML) SOLUTION FOR INJECTION,0005-111805-1021, CHLOROHISTOL 10MG,94640, AIRWAY INHALATION TREATMENT,85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,86140, C REACTIVE PROTEIN,2190-106618-1001, PARAFUSIV,96365, THER/PROPH/DIAG IV INF INIT,0188-135906-2441, PULMICORT,0439-152905-1001, LACTATED RINGERS INJECTION USP,96360, HYDRATION IV INFUSION INIT,96372, THER/PROPH/DIAG INJ SC/IM,96374, THER/PROPH/DIAG INJ IV PUSH,9, Consultation GP **Estimated Cost** :

Prescriptions: 0837-277601-1161 - (OXOMEMAZINE : 0.33 MG/ML) SYRUP,6705-602505-3801 - (HYDROXYPROPYLMETHYLCELLULOSE : 150 MG/ 30ML) SPRAY SOLUTION,2027-719101-0392 - (PARACETAMOL : 500 MG) (IBUPROFEN : 150 MG) (PHENYLEPHRINE HCL : 2.5 MG) FILM COATED TABLETS,0139-116206-1171 - (CLAVULANIC ACID : 125 MG) (AMOXICILLIN : 875 MG) TABLETS, **Estimated Cost** :

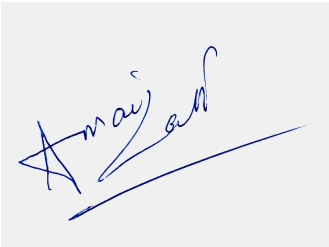
MEDICAL PRACTITIONER DECLARATION :

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 : 26-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 : 26-May-2025