

Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name

: Ali Nasir Nasir
Mahmood Butt

Card No

: I040-029-120505814-01

Policy Holder

: Ali Nasir Nasir
Mahmood Butt

Payer Name

: UNION INSURANCE
COMPANY

TPA

: E CARE - Green Network

Validity

: 01-10-2024 To 30-09-
2025

Gender

: Male

Date Of Birth

: 07-Oct-2002

Patient's Tel No

: 0522068560

Service Date

:31-May-2025

Health Provider

:CITICARE MEDICAL CENTER LLC

Doctor's Name

:DR Amaizah

Co-Insurance

:

Remarks

:

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 : sevre sore throat , bodypain , sneezing , watery eyes , high grade fever
stated 30/05/25 o/e : swollen , hyper,ic pharynx tonsils are swollen

Vitals

:Temp : 36.6 Bp :120 Pulse :82 Resp :16

Clinical Findings:

Diagnosis:

J03.90 - Acute tonsillitis, unspecified,R50.9 - Fever, unspecified,R52 - Pain, unspecified,J30.9 - Allergic rhinitis, unspecified,

Requested Investigations:

0195-107704-0802, CEFTRIAXONE-TABUK IM,2190-106618-1001, PARAFUSIV,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE,96360, HYDRATION IV INFUSION INIT,85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,86140, C REACTIVE PROTEIN,9, Consultation GP

Prescriptions:

0195-123701-0391 - (CETIRIZINE HCL : 10 MG) FILM COATED TABLETS,2027-560101-0391 - (IBUPROFEN : 150 MG) (PARACETAMOL : 500 MG) FILM COATED TABLETS,0397-116206-1171 - (CLAVULANIC ACID : 125 MG) (AMOXICILLIN : 875 MG) TABLETS,6705-602505-3801 - (HYDROXYPROPYLMETHYLCELLULOSE : 150 MG/ 30ML) SPRAY SOLUTION,

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.

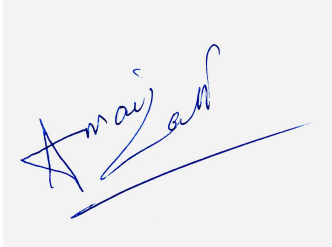
Dr's Name

: DR Amaizah

Stamp :

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

Signature :



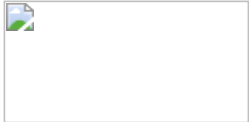
Date :

31-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 :

31-May-2025