Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	**: TEOPISTA NAMIREMBE**
Card No	**: I040-029-121406571-01**
Policy Holder	**: TEOPISTA NAMIREMBE**
Payer Name	**: UNION INSURANCE COMPANY**
TPA	**: E CARE - Blue Network**
Validity	**: 02-01-2025** To **01-01-2026**
Gender	**: Female**
Date Of Birth	**: 29-Nov-1993**
Patient's Tel No	**: 0563549408**

Service Date **:25-Jun-2025** **Network** : Green

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

Doctor's Name **:DR Amaizah**

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 : LOOSE STOOL , ASSOXCIATED WITH CRAMPING ABDOMINAL PAIN , EPIGASTRIC PAIN AND BURNING , LOW GARDE FEVER STARTED 24/06/25 NO HX OF FOOD AND DRUG ALLERGY O/E : LOOK PALE , LETHARGIC DEHYDRATED **Duration:**

Vitals: Temp : 36.4 Bp :112 Pulse :72 Resp :18

Clinical Findings:

Diagnosis: A05.9 - Bacterial foodborne intoxication, unspecified,R19.7 - Diarrhea, unspecified,E86.0 - Dehydration,R10.13 - Epigastric pain, **Date of Onset** :25/47/2025

Requested Investigations: 0439-152905-1001, LACTATED RINGERS INJECTION USP,0195-107704-0801, CEFTRIAXONE-TABUK IV,96360, HYDRATION IV INFUSION INIT,0005-174202-0781, RISEK 40MG,96374, THER/PROPH/DIAG INJ IV PUSH,85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,86140, C REACTIVE PROTEIN,96365, THER/PROPH/DIAG IV INF INIT,9, Consultation GP **Estimated Cost** :

Prescriptions: 0195-116604-0391 - (METRONIDAZOLE : 500 MG) FILM COATED TABLETS,6619-608703-0831 - (SODIUM CHLORIDE : 0.52 G) (POTASSIUM CHLORIDE : 0.3 G) (SODIUM CITRATE : 0.58 G) (GLUCOSE ANHYDROUS : 2.7 G) POWDER FOR SOLUTION, **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.

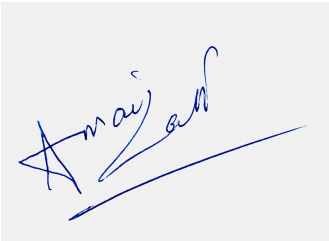
PATIENT'S DECLARATION :

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 Amaizah **Stamp :**

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

Patient 's signature{Parent if minor} : **Date :** 25-Jun-2025

Signature :  **Date** : 25-Jun-2025