

Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name

EHAB IBRAHIM MOHAMED MOUSTAFA

Card No

I040-029-122122057-01

Policy Holder

EHAB IBRAHIM MOHAMED MOUSTAFA

Payer Name

UNION INSURANCE COMPANY

TPA

ECARE-EBP EBP Enhanced CLASIC

Validity

13-01-2025 To 12-01-2026

Gender

Male

Date Of Birth

30-Sep-1989

Patient's Tel No

0558819102

Service Date

:28-Jun-2025

Health Provider

:CITICARE MEDICAL CENTER LLC

Doctor's Name

:DR Amaizah

Co-Insurance

CONSULTATION	LAB/RADIOLOGY	PHYSIO	PHARMACY	IP	MATERNITY	DENTAL
10% max	NIL	NIL	NIL LIMIT	NIL	10%	NA

Network

: Green

Direct Access SP

- YES

Remarks

:

☐ Acute

☐ Pre-existing and chronic

☐ Maternity

Chief Complaints

: pc : severe sore throat , body pain , headache , sneezing low grade fever started 27/06/25 took pcm only not improved o/e : hyperemic pharynx chest : B/L clear

Duration:

Vitals

:Temp : 38.7 Bp :110 Pulse :98 Resp :18

Clinical Findings:

Diagnosis

: J06.9 - Acute upper respiratory infection, unspecified,R05 - Cough,R50.9 - Fever, unspecified,R51.9 - Headache, unspecified,

Date of Onset

:28/49/2025

Requested Investigations

: 0195-107704-0801, CEFTRIAXONE-TABUK IV,2190-106618-1001, PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION,0046-111801-0511, (CHLORPHENIRAMINE : 10 MG) INJECTION,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE,85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,86140, C REACTIVE PROTEIN,96372, THER/PROPH/DIAG INJ SC/IM,94640, AIRWAY INHALATION TREATMENT,96365, THER/PROPH/DIAG IV INF INIT,96374, THER/PROPH/DIAG INJ IV PUSH,9, Consultation GP

Estimated : Cost

Prescriptions

: 0027-265802-1161 - (BUTAMIRATE DIHYDROGEN CITRATE : 0.15% W/V) SYRUP,2027-719101-0392 - (PARACETAMOL : 500 MG) (IBUPROFEN : 150 MG) (PHENYLEPHRINE HCL : 2.5 MG) FILM COATED TABLETS,0397-116206-1171 - (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.

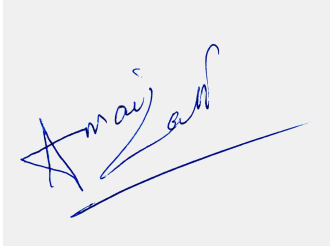
Dr's Name

: DR Amaizah

Stamp :

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

Signature :



Date

: 28-Jun-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}



28-Jun-2025