Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	: **ANGELA WANGUI MAINA**	**Service Date**	:**30-Jun-2025**
Card No	: **I040-029-120110893-01**	**Health Provider**	:**CITICARE MEDICAL CENTER LLC**
Policy Holder	: **ANGELA WANGUI MAINA**	**Doctor's Name**	:**AISHA**
Payer Name	: **UNION INSURANCE COMPANY**	**Co-Insurance**	:
TPA	: **E CARE - Blue Network**	**Remarks**	:
Validity	: **02-01-2025** To **01-01-2026**		
Gender	: **Female**		
Date Of Birth	: **22-Feb-2002**		
Patient's Tel No	: **0553922018**		

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 : throat pain ,fever ,body pain hopc : pt came with the complain of fever ,throat pain along with body pain started one day back o/e tonsils are hypertrophied allergies : none **Duration:**

Vitals: Temp : 36.3 Bp :122 Pulse :90 Resp :18

Clinical Findings:

Diagnosis: J03.90 - Acute tonsillitis, unspecified,R50.9 - Fever, unspecified,R52 - Pain, unspecified,R07.0 - Pain in throat,E86.0 - Dehydration, **Date of Onset** :30/40/2025

Requested Investigations: 85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,86140, C REACTIVE PROTEIN,2190-106618-1001, PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION,96360, HYDRATION IV INFUSION INIT,0439-152905-1001, LACTATED RINGERS INJECTION USP,96365, THER/PROPH/DIAG IV INF INIT,0005-149902-1021, CLOFEN ,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE-(DEXAMETHASONE : 4 MG/ML) SOLUTION FOR INJECTION,96372, THER/PROPH/DIAG INJ SC/IM,0195-107704-0801, CEFTRIAXONE-TABUK IV,96374, THER/PROPH/DIAG INJ IV PUSH **Estimated Cost** :

Prescriptions: 0005-134003-1161 - (BROMHEXINE HYDROCHLORIDE : 4 MG/5ML) SYRUP,0005-107001-0052 - (CAFFEINE : 65 MG) (PARACETAMOL : 500 MG) CAPLETS,0250-125808-1741 - (POVIDONE IODINE : 1%) GARGLE,0397-116207-0391 - (AMOXICILLIN : 500 MG) (CLAVULANIC ACID : 125 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

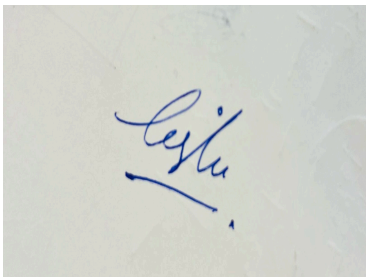
Stamp :

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

Patient 's signature{Parent if minor} :

Date : 30-Jun-2025

Signature :



Date : 30-Jun-2025