

Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name : ANGELA WANGUI MAINA

Card No : I040-029-120110893-01

Policy Holder : ANGELA WANGUI MAINA

Payer Name : UNION INSURANCE COMPANY

TPA : E CARE - Blue Network

Validity : 02-01-2025 To 01-01-2026

Gender : Female

Date Of Birth : 22-Feb-2002

Patient's Tel No : 0553922018

Service Date :02-Jul-2025

Health Provider :CITICARE MEDICAL CENTER LLC

Doctor's Name :AISHA

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 : 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 follow up crp high 29 2ND dose of antibiotic given

Vitals:Temp : 36.8 Bp :110 Pulse :74 Resp :18

Clinical Findings:

Diagnosis: J03.90 - Acute tonsillitis, unspecified,R07.0 - Pain in throat,E86.0 - Dehydration, Date of Onset :02/21/2025

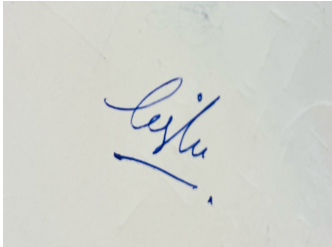
Requested Investigations: 0195-107704-0801, CEFTRIAXONE-TABUK IV,0439-152905-1001, LACTATED RINGERS INJECTION USP,96365, THER/PROPH/DIAG IV INF INIT,96360, HYDRATION IV INFUSION INIT

Estimated Cost :

Prescriptions:

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 : AISHA

Signature : 

Stamp :

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

Date : 02-Jul-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 : Jul-2025