Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	: **TEOPISTA NAMIREMBE**	**Service Date**	:**02-Jul-2025** **Network** : Green
Card No	: **I040-029-121406571-01**	**Health Provider**	:**CITICARE MEDICAL CENTER LLC** **Direct Access SP - YES**
Policy Holder	: **TEOPISTA NAMIREMBE**	**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	: **29-Nov-1993**		
Patient's Tel No	: **0563549408**		

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 : HEADACHE AND WEAKNESS HOPC : PT CAME WITH THE COMPLAIN OF HEADACHE AND GENERALIZE WEAKNESS STARTED THREE DAYS BACK O/E SHE LOOK PALE AND DEHYDRATED ALLERGIES : NONE PMH : NONE **Duration:**

Vitals: Temp : 36.4 Bp :125 Pulse :72 Resp :18

Clinical Findings:

Diagnosis: R53.1 - Weakness,R52 - Pain, unspecified,R51.9 - Headache, unspecified,D64.9 - Anemia, unspecified, **Date of Onset:**02/33/2025

Requested Investigations: 85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,2190-106618-1001, PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION,0439-152905-1001, LACTATED RINGERS INJECTION USP,96360, HYDRATION IV INFUSION INIT,96374, THER/PROPH/DIAG INJ IV PUSH,9, Consultation GP **Estimated Cost** :

Prescriptions: 2027-719101-0391 - (PARACETAMOL : 500 MG) (IBUPROFEN : 150 MG) (PHENYLEPHRINE HCL : 2.5 MG) FILM COATED TABLETS,5254-830602-2401 - (VITAMIN B1 (THIAMINE) : 100 MG) (VITAMIN B6 (AS PYRIDOXINE HCL) : 200 MG) (VITAMIN B12 (CYANOCOBALAMIN) : 200 MCG) SUGAR 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

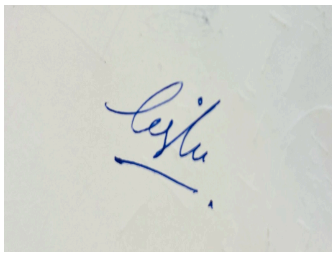
Stamp :

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

Patient 's signature{Parent if minor} :

Date : 02-Jul-2025

Signature :



Date : 02-Jul-2025