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 :**03-Jul-2025** **Network** : Green

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

Doctor's Name :**AISHA**

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 : PC : SEVER STOMACH PAIN HOPC : PT CAME WITHTHE COMPALIN OF STOMACH PAIN ALONG WITH HEART BURN STARTED THIS MORNING SHE ALSO COMPLAIN OF LOSS OF APPETITE AS WELL O/E SHE LOOK PALE AND DEHYDRATED ABD.TENDERNESS ALLERGIES : NONE PMH : NONE HB IS LOW **Duration:**

Vitals: Temp : 36.6 Bp :128 Pulse :78 Resp :18

Clinical Findings:

Diagnosis: K29.00 - Acute gastritis without bleeding,R12 - Heartburn,R10.819 - Abdominal tenderness, unspecified site, **Date of Onset** :03/19/2025

Requested Investigations: 0005-136504-1021, SCOPINAL,96372, THER/PROPH/DIAG INJ SC/IM,0005-174202-0781, RISEK 40MG-(OMEPRAZOLE : 40 MG) POWDER FOR INFUSION,96374, THER/PROPH/DIAG INJ IV PUSH,0439-152905-1001, LACTATED RINGERS INJECTION USP,96360, HYDRATION IV INFUSION INIT **Estimated Cost** :

Prescriptions: **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

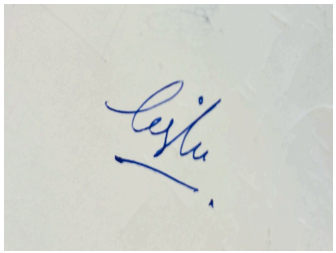
Stamp :

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

Patient 's signature{Parent if minor} :

Date : 03-Jul-2025

Signature :



Date : 03-Jul-2025