Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	**: NAREEKA KAINTH**
Card No	**: I040-029-121210616-01**
Policy Holder	**: NAREEKA KAINTH**
Payer Name	**: UNION INSURANCE COMPANY**
TPA	**: E CARE - Blue Network**
Validity	**: 05-02-2025** To **04-02-2026**
Gender	**: Female**
Date Of Birth	**: 07-Aug-1994**
Patient's Tel No	**: 0503567708**

Service Date **:08-Jul-2025** **Network** **:** Green

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

Doctor's Name **:SANDIA**

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 : Pt complaints of generalised abdominal pain associated with loose stools ,bloating and abdominal distension from the last 4 days Pt gives a history of mixed food intake from restaurant and home She also had fever and itching in the body yesterday On examination Dehydrated and tired,nausea present **Duration:**

Vitals: Temp : 36.6 Bp :94 Pulse :60 Resp :18

Clinical Findings:

Diagnosis: A09 - Infectious gastroenteritis and colitis, unspecified,R50.9 - Fever, unspecified,R11.0 - Nausea,K29.00 - Acute gastritis without bleeding,R10.84 - Generalized abdominal pain, **Date of Onset** **:**08/46/2025

Requested Investigations: 0005-136504-1021, SCOPINAL,0005-174202-0781, RISEK 40MG,85027, BLOOD COUNT COMPLETE AUTOMATED,86140, C REACTIVE PROTEIN,96365, THER/PROPH/DIAG IV INF INIT,96372, THER/PROPH/DIAG INJ SC/IM,9, Consultation GP **Estimated Cost** :

Prescriptions: 0097-230603-0831 - (ORAL REHYDRATION SALTS (O.R.S.) : N/A) POWDER FOR SOLUTION,1553-571101-0061 - (BIFIDOBACTERIUM LONGUM : 200000000 CFU) (LACTOBACILLUS GASSERI : 200000000 CFU) (BIFIDOBACTERIUM BIFIDUM : 200000000 CFU) CAPSULES,0207-533801-1451 - (ESOMEPRAZOLE (AS MAGNESIUM) : 20 MG) CAPSULES (HARD GELATIN),0042-136501-1171 - (HYOSCINE : 10 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 : SANDIA

Stamp :

Dr. Sandia Bhojwani
General Practitioner
DHA No: 65900212-001
PESHAWAR MEDICAL CENTER LLC
DUBAI - U.A.E.

Signature : 

Date : 08-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 : 08-Jul-2025