Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	**: FETHI ACHI**
Card No	**: I040-029-121180791-01**
Policy Holder	**: FETHI ACHI**
Payer Name	**: UNION INSURANCE COMPANY**
TPA	**: E CARE - Blue Network**
Validity	**: 02-01-2025** To **01-01-2026**
Gender	**: Male**
Date Of Birth	**: 17-Nov-1999**
Patient's Tel No	**: 0581127489**

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 : Came for routine checkup Pt complaints of tiredness and acne over the face and nape of neck Food habits include red meat, junk food On examination nodular acne present,Vit D3 22.9 Known hypothyroidism on medication **Duration:**

Vitals: Temp : 36.6 Bp :132 Pulse :72 Resp :18

Clinical Findings:

Diagnosis: R53.82 - Chronic fatigue, unspecified,R53.81 - Other malaise,L70.0 - Acne vulgaris,E03.9 - Hypothyroidism, unspecified, **Date of Onset** **:**08/04/2025

Estimated Cost **:**

Requested Investigations: 9, Consultation GP

Estimated Cost :

Prescriptions: 5915-640420-0061 - (VITAMIN D3 (CHOLECALCIFEROL) : 10000 IU) CAPSULES,

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 **:** SANDIA **Stamp :**

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

Patient 's signature{Parent if minor} **:** **Date :** 08-Jul-2025

Signature : **Date** **:** 08-Jul-2025