Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	**: MONICA RAM DATT SHARMA**
Card No	**: I040-029-117518711-01**
Policy Holder	**: MONICA RAM DATT SHARMA**
Payer Name	**: UNION INSURANCE COMPANY**
TPA	**: E CARE - Blue Network**
Validity	**: 02-01-2025** To **01-01-2026**
Gender	**: Female**
Date Of Birth	**: 16-Mar-1995**
Patient's Tel No	**: 0509706442**

Service Date :**10-Aug-2025** **Network** : Green

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

Doctor's Name :**DR Amaizah**

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 : follw up pyuria erythroctyes in urine proteinuria leukocyte estrase positive ascending urinary tract infection with pyelonephritis 2nd dose of iv antibiotic today **Duration:**

Vitals: Temp : 37.3 Bp :120 Pulse :80 Resp :22

Clinical Findings:

Diagnosis: N39.0 - Urinary tract infection, site not specified,N10 - Acute pyelonephritis,R30.0 - Dysuria,R52 - Pain, unspecified, **Date of Onset** :10/36/2025

Requested Investigations: 0195-107704-0801, CEFTRIAXONE-TABUK IV,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE,96372, THER/PROPH/DIAG INJ SC/IM,96374, THER/PROPH/DIAG INJ IV PUSH **Estimated Cost** :

Prescriptions: 6619-548302-0251 - (SODIUM BICARBONATE : 1.76G) (SODIUM CITRATE ANHYDROUS : 0.63G) (TARTARIC ACID : 0.89G) (CITRIC ACID ANHYDROUS : 0.715 G) EFFERVESCENT GRANULES, **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.

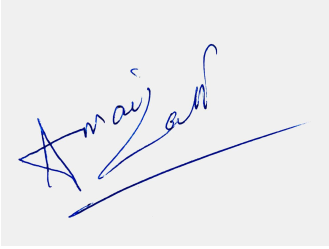
PATIENT'S DECLARATION :

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 : DR Amaizah **Stamp :**

Dr. Amaizah Ishtiaq
General Practitioner
DHA: 98486553-001
CITICARE MEDICAL CENTER
DUBAI - U.A.E

Patient 's signature{Parent if minor} : **Date** : 10-Aug-2025

Signature :  **Date** : 10-Aug-2025