## Administrative

# MEDICAL CLAIM FORM

## Claim Ref:

| | |
|---|---|
| **Patient Name** | : **AMIR BAHADUR BIST** |
| **Card No** | : **I040-029-118843244-01** |
| **Policy Holder** | : **AMIR BAHADUR BIST** |
| **Payer Name** | : **UNION INSURANCE COMPANY** |
| **TPA** | : **E CARE - Blue Network** |
| **Validity** | : **02-01-2025** To **01-01-2026** |
| **Gender** | : **Male** |
| **Date Of Birth** | : **27-Sep-1999** |
| **Patient's Tel No** | : **0569752337** |

**Service Date** :**14-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 :** PC : BODYPAIN , HEADCAHE , FREQUENT SNEEZING AND LOW BACK PAIN STARTED 10/08/25 HCX OF PARACETAMOL ALLERGY O/E : HYPEREMIC PHARYNX **Duration:**

**Vitals:**Temp : 36.3 Bp :110 Pulse :60 Resp :18

**Clinical Findings:**

**Diagnosis:** J06.9 - Acute upper respiratory infection, unspecified,R50.9 - Fever, unspecified,M54.5 - Low back pain, **Date of Onset** :14/57/2025

**Requested Investigations:** 85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,86140, C REACTIVE PROTEIN,9, Consultation GP **Estimated Cost** :

**Prescriptions:** 0195-123701-0391 - (CETIRIZINE HCL : 10 MG) FILM COATED TABLETS,0027-149906-1171 - (DICLOFENAC SODIUM : 25 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.

**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 :** 14-Aug-2025

**Signature :**

**Date** : 14-Aug-2025