Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	: **ANKUSH RAMESH PATIL RAMESH TAIL**
Card No	: **I040-029-118045856-01**
Policy Holder	: **ANKUSH RAMESH PATIL RAMESH TAIL**
Payer Name	: **UNION INSURANCE COMPANY**
TPA	: **E CARE - Blue Network**
Validity	: **02-01-2025** To **01-01-2026**
Gender	: **Male**
Date Of Birth	: **07-May-1998**
Patient's Tel No	: **0521674564**

Service Date :**17-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 : SEVRE SORE THROAT , BODY PAIN , HEDACHE , AND FEVER STARTED 13/08/25 SNEEZING NASAL CONGESTION COUGH WITH SPUTUM O/E : PALE . LETHARGIC , DEHYDRATED HYPEREMIC PHARYNX CHEST WHEEZING **Duration:**

Vitals: Temp : 36.8 Bp :130 Pulse :78 Resp :18

Clinical Findings:

Diagnosis: J02.9 - Acute pharyngitis, unspecified,R50.9 - Fever, unspecified,R06.2 - Wheezing,J30.9 - Allergic rhinitis, unspecified,R05 - Cough,R09.81 - Nasal congestion, **Date of Onset** :17/12/2025

Requested Investigations: 85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,86140, C REACTIVE PROTEIN,94640, AIRWAY INHALATION TREATMENT,0188-135906-2441, PULMICORT,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE,0005-111805-1021, CHLOROHISTOL 10MG,96372, THER/PROPH/DIAG INJ SC/IM,9, Consultation GP **Estimated Cost** :

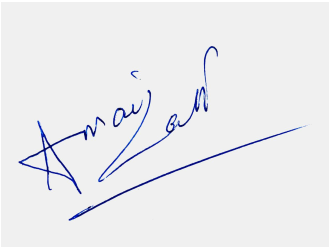
Prescriptions: 0006-107103-0391 - (DIPHENHYDRAMINE : 25 MG) (PARACETAMOL : 500 MG) FILM COATED TABLETS,0027-128802-2021 - (XYLOMETAZOLINE HYDROCHLORIDE : 0.1%) NASAL DROPS,0397-116206-1171 - (CLAVULANIC ACID : 125 MG) (AMOXICILLIN : 875 MG) TABLETS,0027-265802-1161 - (BUTAMIRATE DIHYDROGEN CITRATE : 0.15% W/V) SYRUP, **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 : DR Amaizah **Stamp :**

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

Signature : 

Date : 17-Aug-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 : 17-Aug-2025