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 **:20-Aug-2025** **Network** : Green

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

Doctor's Name **:AISHA**

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 : fever , throat pain , body pain and itching hopc : pt came with the complain of fever along with body pain and throat pain started yesterday o/e throat is mild hyperemic chest is clear allergies : none she has low blood pressure **Duration:**

Vitals: Temp : 37 Bp :100 Pulse :80 Resp :18

Clinical Findings:

Diagnosis: J06.9 - Acute upper respiratory infection, unspecified,R50.9 - Fever, unspecified,R07.0 - Pain in throat,J45.991 - Cough variant asthma,I95.9 - Hypotension, unspecified,E86.0 - Dehydration,R21 - Rash and other nonspecific skin eruption,L29.8 - Other pruritus, **Date of Onset** :20/23/2025

Requested Investigations: 85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,86140, C REACTIVE PROTEIN,82785, GAMMAGLOBULIN IGE,0005-111805-1021, CHLOROHISTOL 10MG,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE,96372, THER/PROPH/DIAG INJ SC/IM,2190-106618-1001, PARAFUSIV,96365, THER/PROPH/DIAG IV INF INIT,96360, HYDRATION IV INFUSION INIT,0005-149902-1021, CLOFEN ,9, Consultation GP,0384-111908-1001, SODIUM CHLORIDE B.P. **Estimated Cost** :

Prescriptions: 6705-602505-3801 - (HYDROXYPROPYLMETHYLCELLULOSE : 150 MG/ 30ML) SPRAY SOLUTION,0009-127405-0391 - (AZITHROMYCIN : 500 MG) FILM COATED TABLETS,0005-107001-0052 - (CAFFEINE : 65 MG) (PARACETAMOL : 500 MG) CAPLETS,0005-119803-1171 - (PREDNISOLONE : 20 MG) TABLETS,0195-123701-0391 - (CETIRIZINE HCL : 10 MG) FILM COATED 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 : AISHA

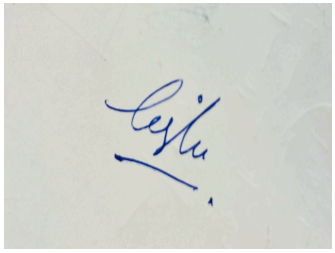
Stamp :

Dr. Aisha Umer
Physician- General Practitioner
DHA- 40131439-002
CITICARE MEDICAL CENTER
DUBAI - U.A.E

Patient 's signature{Parent if minor} :

Date : 20-Aug-2025

Signature :



Date : 20-Aug-2025