Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	: **MOHAMMED SHAHAB UDDIN ABDUL MABUD**	**Service Date**	**:30-Aug-2024**	**Network**	: Green
Card No	: **I040-029-119600415-01**	**Health Provider**	**:CITICARE MEDICAL CENTER LLC**	**Direct Access SP - YES**	
Policy Holder	: **MOHAMMED SHAHAB UDDIN ABDUL MABUD**	**Doctor's Name**	**:Humaira**		
Payer Name	: **UNION INSURANCE COMPANY**	**Co-Insurance**	:		
TPA	: **E CARE - Blue Network**	**Remarks**	:		
Validity	: **02-01-2024** To **01-01-2025**				
Gender	: **Male**				
Date Of Birth	: **08-Mar-1985**				
Patient's Tel No	: **0581676397**				

CONSULTATION	LAB/RADIOLOGY	PHYSIO	PHARMACY	IP	MATERNITY	DENTAL
10% max	NIL	NIL	NIL LIMIT	NIL	10%	NA

☐ **Acute** ☐ **Pre-existing and chronic** ☐ **Maternity**

Chief Complaints : co running nose dry cough fever on and off 27th august 2024 oe chest is congested no added sounds restless taking tablet penadol at home has skin allergy taking t. cetrazine 5mg daily from 3 days **Duration:**

Vitals: Temp : 36.8 Bp :126 Pulse :88 Resp :18

Clinical Findings:

Diagnosis: R50.9 - Fever, unspecified,J06.9 - Acute upper respiratory infection, unspecified,R05 - Cough,R52 - Pain, unspecified, **Date of Onset** :30/20/2024

Requested Investigations: 85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,85652, SEDIMENTATION RATE RBC AUTOMATED,86140, C REACTIVE PROTEIN,0195-107704-0801, CEFTRIAXONE-TABUK IV,0005-149902-1021, CLOFEN -(DICLOFENAC SODIUM : 75 MG/3ML) SOLUTION FOR INJECTION,96372, THER/PROPH/DIAG INJ SC/IM,96365, THER/PROPH/DIAG IV INF INIT,9, Consultation GP **Estimated Cost** :

Prescriptions: 0097-393801-2471 - (AMMONIUM CHLORIDE : 131.5 MG/5 ML) (DIPHENHYDRAMINE HCL : 13.5 MG/5ML) SYRUP (ALCOHOL FREE),0005-107001-0051 - (CAFFEINE : 65 MG) (PARACETAMOL : 500 MG) CAPLETS,0139-116206-1171 - (CLAVULANIC ACID : 125 MG) (AMOXICILLIN : 875 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.

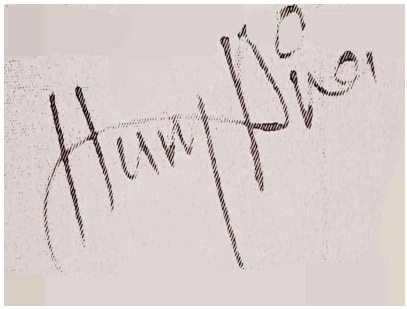
Dr's Name : Humaira

Stamp :

Dr. Humaira Mumtaz
General Practitioner
DHA No: 54155530-002
CITICARE MEDICAL CENTER LLC
DUBAI - U.A.E.

Patient 's signature{Parent : if minor}

Date : 30-Aug-2024

Signature : 

Date : 30-Aug-2024