

Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name : FETHI ACHI Service Date : 22-Jan-2025 Network : Green
Card No : I040-029-121180791-01 Health Provider : CITICARE MEDICAL CENTER LLC Direct Access SP - YES
Policy Holder : FETHI ACHI Doctor's Name : DR Amaizah
Payer Name : UNION INSURANCE COMPANY Co-Insurance :

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

TPA : E CARE - Blue Network Remarks :
Validity : 02-01-2025 To 01-01-2026
Gender : Male
Date Of Birth : 17-Nov-1999
Patient's Tel No : 0581127489

☐ Acute ☐ Pre-existing and chronic ☐ Maternity

Chief Complaints : pc : soreness in throat persistant not improved with meds labs are normal Duration: known hypothyroidism on thyroxin

Vitals:Temp : 36 Bp :121 Pulse :98 Resp :18

Clinical Findings:

Diagnosis: E03.9 - Hypothyroidism, unspecified, Date of Onset : 30/14/2025

Requested Investigations: 9.01, Follow Up Consultation GP,0188-135906-2441, PULMICORT- (BUDESONIDE : 0.5 MG/ML) SUSPENSION FOR NEBULIZATION,94640, AIRWAY INHALATION TREATMENT Estimated Cost :

Prescriptions: 6705-602505-3801 - (HYDROXYPROPYLMETHYLCELLULOSE : 150 MG/ 30ML) SPRAY SOLUTION, 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

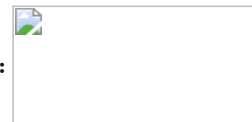
Stamp :



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}



30- Jan- 2025

Signature :

Date : 30-Jan-2025