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**	**:**		
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**				

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

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.

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 :** 30-Jan-2025

Signature : **Date** **:** 30-Jan-2025