Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	**: AYBARS EGE YILMAZ**
Card No	**: I040-029-122205314-01**
Policy Holder	**: AYBARS EGE YILMAZ**
Payer Name	**: UNION INSURANCE COMPANY**
TPA	**: E CARE - Blue Network**
Validity	**: 13-01-2025** To **12-01-2026**
Gender	**: Male**
Date Of Birth	**: 02-Sep-2001**
Patient's Tel No	**: 0557414729**

Service Date **:23-Mar-2025** **Network** **:** Green

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

Doctor's Name **:Humaira**

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 : high grade fever pain in throat cough body pain headache cold o/e there is hyperemia and chest congesion **Duration:**

Vitals: Temp : 38.3 Bp :112 Pulse :109 Resp :0

Clinical Findings:

Diagnosis: J02.9 - Acute pharyngitis, unspecified,R50.9 - Fever, unspecified,R05 - Cough,R07.0 - Pain in throat,M54.5 - Low back pain,R09.81 - Nasal congestion, **Date of Onset** **:**23/41/2025

Requested Investigations: 2190-106618-1001, PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION,96365, THER/PROPH/DIAG IV INF INIT,85027, BLOOD COUNT COMPLETE AUTOMATED,86140, C REACTIVE PROTEIN,9, Consultation GP **Estimated Cost** **:**

Prescriptions: 0097-127402-0391 - (AZITHROMYCIN : 250 MG) FILM COATED TABLETS,0031-149904-1171 - (DICLOFENAC SODIUM : 50 MG) TABLETS,0006-106601-0393 - (PARACETAMOL : 500 MG) FILM COATED TABLETS,0097-395404-0391 - (MONTELUKAST (AS SODIUM : 10 MG FILM COATED TABLETS,0207-169703-1161 - (AMMONIUM CHLORIDE : N/A) (DIPHENHYDRAMINE : N/A) 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.

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

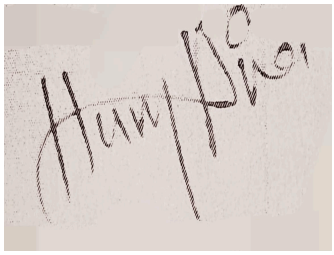
Stamp :

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

Patient 's signature{Parent : if minor}

Date : 23-Mar-2025

Signature :



Date **:** 23-Mar-2025