

Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name

: POLA WAGDY FAHIM

Card No

: I011-029-118504990-01

Policy Holder

: POLA WAGDY FAHIM

Payer Name

: AL SAGR NATIONAL INSURANCE COMPANY

TPA

: E CARE - Blue Network

Validity

: 22-08-2023 To 21-08-2024

Gender

: Male

Date Of Birth

: 02-Jul-1997

Patient's Tel No

: 0504122610

Service Date

:29-Jun-2024

Health Provider

:CITICARE MEDICAL CENTER LLC

Doctor's Name

:Enomen Goodluck

Co-Insurance

:

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

Network

: Green

Direct Access SP

- YES

☐ Acute

☐ Pre-existing and chronic

☐ Maternity

Chief Complaints

: PC: Cough, pain in throat and fever Duration: since yesterday 2days. Duration:

Associated with generalized body pains. Has associated nausea and upper abdominal pain after a meal.

Vitals

:Temp : 37.4 Bp :118 Pulse :86 Resp :18

Clinical Findings:

Diagnosis

: J06.9 - Acute upper respiratory infection, unspecified,K29.00 - Acute gastritis without bleeding,R50.9 - Fever, unspecified,

Date of Onset

:29/06/2024

Requested Investigations

: 85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,86140, C REACTIVE PROTEIN,9, Consultation GP

Estimated Cost

:

Prescriptions

: 4874-125821-3801 - (POVIDONE IODINE : 0.45%) SPRAY SOLUTION,0070-148701-1171 - (LORATADINE : 10 MG) TABLETS,0005-119805-1172 - (PREDNISOLONE : 5 MG) TABLETS,0252-185801-0391 - (DIPHENHYDRAMINE : 25 MG) (PARACETAMOL : 500 MG) (PSEUDOEPHEDRINE : 30 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.

Dr's Name

: Enomen Goodluck

Stamp :

Dr. Enomen Goodluck Ekata
General Practitioner
DHA No: 28040827-001
CITICARE MEDICAL CENTER LLC
DUBAI - U.A.E.

Signature :

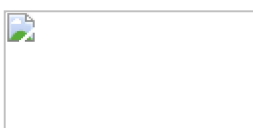


Date : 29-Jun-2024

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}



Date : Jun-2024

https://irhamc.visionsoftwares.ae/mr_ecare_claim_print.aspx?appld=49533&patId=52542

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