

Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name : GABE EMMANUELLE MORCILLA . .

Card No : I011-029-120515766-03

Policy Holder : GABE EMMANUELLE MORCILLA . .

Payer Name : AL SAGR NATIONAL INSURANCE COMPANY

TPA : E CARE - Blue Network

Validity : 01-07-2024 To 30-06-2025

Gender : Male

Date Of Birth : 22-Sep-2002

Patient's Tel No : 0589578846

Service Date:26-Jul-2024

Health Provider :CITICARE MEDICAL CENTER LLC

Doctor's Name :Humaira

Co-Insurance :

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

Remarks :

Network : Green

Direct Access SP - YES

☐ Acute

☐ Pre-existing and chronic

☐ Maternity

Chief Complaints : co fever on and off running nose 23rd july 2024 oe enlarge tonsills chest is congested no added sounds restless

Vitals:Temp : 36.5 Bp :128 Pulse :78 Resp :18

Clinical Findings:

Diagnosis: R50.9 - Fever, unspecified,J06.9 - Acute upper respiratory infection, unspecified,J30.9 - Allergic rhinitis, unspecified, Date of Onset :26/53/2024

Requested Investigations: 85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,86140, C REACTIVE PROTEIN,85652, SEDIMENTATION RATE RBC AUTOMATED,0005-111805-1021, CHLOROHISTOL 10MG-(CHLORPHENIRAMINE MALEATE : 10 MG/ML) SOLUTION FOR INJECTION,96372, THER/PROPH/DIAG INJ SC/IM,9, Consultation GP,85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,86140, C REACTIVE PROTEIN,85651, SEDIMENTATION RATE RBC NON AUTOMATED,85651, SEDIMENTATION RATE RBC NON AUTOMATED,86140, C REACTIVE PROTEIN,85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT

Prescriptions: 0195-123701-0391 - (CETIRIZINE HCL : 10 MG) FILM COATED TABLETS,

Estimated Cost :

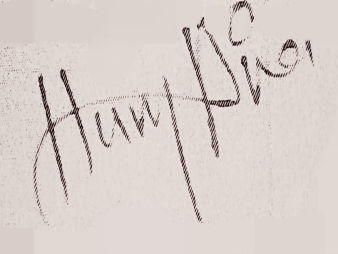
Estimated Cost :

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 : Humaira

Stamp :

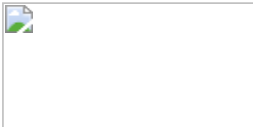
Dr. Humaira Mumtaz
General Practitioner
DHA No: 54155530-002
CITICARE MEDICAL CENTER LLC
DUBAI - U.A.E.

Signature :

Date : 26-Jul-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}



26-Jul-2024

https://irhamc.visionsoftwares.ae/mr_ecare_claim_print.aspx?appld=50196&patId=53302

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