

Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name

: GABE EMMANUELLE
GETIGAN MORCILLA

Card No

: I011-029-120515766-03

Policy Holder

: GABE EMMANUELLE
GETIGAN 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

:04-Sep-2024

Health Provider

:CITICARE MEDICAL CENTER LLC

Doctor's Name

:AHSAN HUSSAIN

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

Remarks

:

☐ Acute

☐ Pre-existing and chronic

☐ Maternity

Chief Complaints

: PC: RUNNY NOSE ALLERGIC RHINITIS INSOMNIA MUSCLE WEAKNESS

Duration

:

Vitals

:Temp : 37.1 Bp :118 Pulse :103 Resp :18

Clinical Findings

:

Diagnosis

: J30.9 - Allergic rhinitis, unspecified,J34.2 - Deviated nasal septum,M54.5 - Low back pain,

Date of Onset

:05/08/2024

Estimated Cost

:

Requested Investigations

: 9, Consultation GP

Prescriptions

: 0027-296201-1971 - (XYLOMETAZOLINE HCL (MENTHOL) : 0.1%) LIQUID FOR SPRAY (NASAL),1217-373201-2401 - TOLPERISONE HCL,0195-123701-0391 - CETIRIZINE HCL,

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

: AHSAN HUSSAIN

Stamp

Dr. Ahsan Hussain

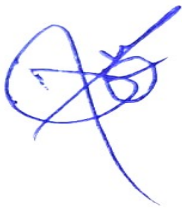
General Practitioner

DHA No: 87543658-001

CITICARE MEDICAL CENTER LLC

DUBAI - U.A.E.

Signature



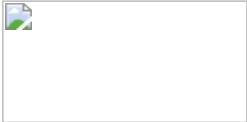
Date

: 05-Sep-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

: Sep-2024