Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	: **GABE EMMANUELLE GETIGAN MORCILLA**	**Service Date**	:**04-Sep-2024** **Network** : Green
Card No	: **I011-029-120515766-03**	**Health Provider**	:**CITICARE MEDICAL CENTER LLC** **Direct Access SP - YES**
Policy Holder	: **GABE EMMANUELLE GETIGAN MORCILLA**	**Doctor's Name**	:**AHSAN HUSSAIN**
Payer Name	: **AL SAGR NATIONAL INSURANCE COMPANY**	**Co-Insurance**	:
TPA	: **E CARE - Blue Network**	**Remarks**	:
Validity	: **01-07-2024** To **30-06-2025**		
Gender	: **Male**		
Date Of Birth	: **22-Sep-2002**		
Patient's Tel No	: **0589578846**		

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: 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.

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 : AHSAN HUSSAIN **Stamp :**

Dr. Ahsan Hussain
General Practitioner
DHA No: 87543658-001
CITICARE MEDICAL CENTER LLC
DUBAI - U.A.E.

Patient 's signature{Parent if minor} : **Date** : 05-Sep-2024

Signature : **Date** : 05-Sep-2024