Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	**: HASSAN SHAHID**
Card No	**: I011-029-120623404-01**
Policy Holder	**: HASSAN SHAHID**
Payer Name	**: AL SAGR NATIONAL INSURANCE COMPANY**
TPA	**: E CARE - Blue Network**
Validity	**: 10-02-2024** To **09-02-2025**
Gender	**: Male**
Date Of Birth	**: 29-Oct-1983**
Patient's Tel No	**: 0553553660**

Service Date :15-Oct-2024 **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 : co increase freguency of urination thirst pallor dehydration sep 2024 oe chest is clear no added sounds restless smoker **Duration:**

Vitals: Temp : 36.6 Bp :102 Pulse :78 Resp :18

Clinical Findings:

Diagnosis: D64.9 - Anemia, unspecified,R23.1 - Pallor,E86.0 - Dehydration, **Date of Onset** :15/17/2024

Requested Investigations: 82948, REAGENT STRIP/BLOOD GLUCOSE,83036, HEMOGLOBIN GLYCOSYLATED A1C,83540, IRON,83550, IRON BINDING CAPACITY,0102-111908-1001, SODIUM CHLORIDE B.P.,96360, HYDRATION IV INFUSION INIT,9, Consultation GP **Estimated Cost** :

Prescriptions: **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.

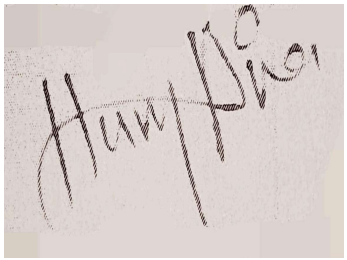
PATIENT'S DECLARATION :

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 :** 15-Oct-2024

Signature :  **Date** : 15-Oct-2024