Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	: HASSAN SHAHID	**Service Date**	:17-Oct-2024
Card No	: I011-029-120623404-01	**Health Provider**	:CITICARE MEDICAL CENTER LLC
Policy Holder	: HASSAN SHAHID	**Doctor's Name**	:Humaira
Payer Name	: AL SAGR NATIONAL INSURANCE COMPANY	**Co-Insurance**	:
TPA	: E CARE - Blue Network	**Remarks**	:
Validity	: 10-02-2024 To 09-02-2025		
Gender	: Male		
Date Of Birth	: 29-Oct-1983		
Patient's Tel No	: 0553553660		

Network : Green

Direct Access SP - YES

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 : **Duration :**

Vitals: Temp : 36.6 Bp :120 Pulse :102 Resp :18

Clinical Findings:

Diagnosis: D64.9 - Anemia, unspecified,R23.1 - Pallor,E86.0 - Dehydration,E78.5 - Hyperlipidemia, unspecified,E55.9 - Vitamin D deficiency, unspecified, **Date of Onset** :17/06/2024

Estimated Cost :

Requested Investigations: 9.01, Follow Up Consultation GP

Prescriptions: 1290-640422-1171 - (VITAMIN D3 (CHOLECALCIFEROL) : 5000 IU) TABLETS,0252-182103-0081 - (IRON (AS FERRIC/FERROUS HYDROXIDE POLYMALTOSE COMPLEX) : 100 MG) CHEWABLE TABLETS,1724-386001-0391 - (ATORVASTATIN (AS CALCIUM) : 10 MG) FILM COATED TABLETS,

Estimated Cost :

MEDICAL PRACTITIONER DECLARATION :

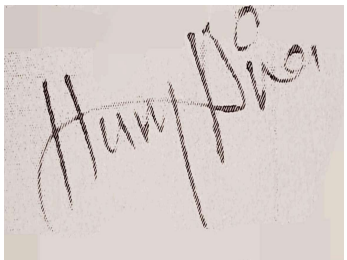
I declare that I am the patient's medical practitioner and that the particulars given are to the best of my knowledge true and correct.

Dr's Name : Humaira

Stamp :

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

Signature :



Date : 17-Oct-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 : 17-Oct-2024