Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	**: SUHAIL DAR ABDULRASHID**	**Service Date:**	**24-Oct-2024**
Card No	**: I035-029-118290553-01**	**Health Provider**	**:CITICARE MEDICAL CENTER LLC**
Policy Holder	**: SUHAIL DAR ABDULRASHID**	**Doctor's Name**	**:AHSAN HUSSAIN**
Payer Name	**: SALAMA – Islamic Arab Insurance Company**	**Co-Insurance**	:
TPA	**: ECARE-EBP EBP Enhanced CLASSIC_H**	**Remarks**	**:**
Validity	**: 15-02-2024** To **14-02-2025**		
Gender	**: Male**		
Date Of Birth	**: 23-Feb-1989**		
Patient's Tel No	**: 0523268753**		

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 : PC: FEELING STRESSED SHIVERING BLOOD PRESSURE 152/82 BODY PAIN **Duration :**

Vitals: Temp : 36.4 Bp :152 Pulse :76 Resp :18

Clinical Findings:

Diagnosis: F41.9 - Anxiety disorder, unspecified,E86.0 - Dehydration,I10 - Essential (primary) hypertension,M54.5 - Low back pain,M62.830 - Muscle spasm of back,G43.D0 - Abdominal migraine, not intractable, **Date of Onset** :24/44/2024

Requested Investigations: 2190-106618-1001, PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION,0102-152902-1001, LACTATED RINGERS INJECTION USP,96365, THER/PROPH/DIAG IV INF INIT,2104-379202-1451, (AMLODIPINE (AS BESYLATE) : 10 MG) CAPSULES (HARD GELATIN),9, Consultation GP,0005-149902-1021, CLOFEN ,96372, THER/PROPH/DIAG INJ SC/IM,SC, SERVICE CHARGE **Estimated Cost** :

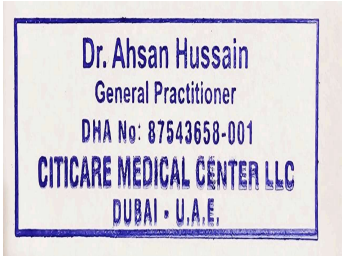
Prescriptions: 1162-699701-0391 - (ACETYLSALICYLIC ACID : 250 MG) (CAFFEINE : 65 MG) (PARACETAMOL : 250 MG) FILM COATED TABLETS,0195-379202-1451 - (AMLODIPINE (AS BESYLATE) : 10 MG) CAPSULES (HARD GELATIN),1217-373201-2401 - (TOLPERISONE : 150 MG) SUGAR COATED TABLETS, **Estimated Cost** :

MEDICAL PRACTITIONER DECLARATION :

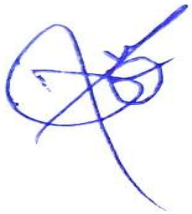
I declare that I am the patient's medical practitioner and that the particulars given are to the best of my knowledge true and correct.

Dr's Name : AHSAN HUSSAIN

Stamp :



Signature :



Date : 24-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 : 24-Oct-2024