Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	: **ZEESHAN AHMAD AZIZ AHMAD**	**Service Date**	:**14-Nov-2024** **Network** : Green
Card No	: **I011-029-119743227-02**	**Health Provider**	:**CITICARE MEDICAL CENTER LLC** **Direct Access SP - YES**
Policy Holder	: **ZEESHAN AHMAD AZIZ AHMAD**	**Doctor's Name**	:**AHSAN HUSSAIN**
Payer Name	: **AL SAGR NATIONAL INSURANCE COMPANY**	**Co-Insurance**	:
TPA	: **E CARE - Blue Network**	**Remarks**	:
Validity	: **19-06-2024** To **18-06-2025**		
Gender	: **Male**		
Date Of Birth	: **07-Jan-1990**		
Patient's Tel No	: **0561427224**		

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: fever 1 day flu 1 day cough 1 day body pain 1 day **Duration :**

Vitals: Temp : 36.4 Bp :130 Pulse :70 Resp :0

Clinical Findings:

Diagnosis: J06.9 - Acute upper respiratory infection, unspecified,J00 - Acute nasopharyngitis [common cold],J20.9 - Acute bronchitis, unspecified,R50.9 - Fever, unspecified,M54.5 - Low back pain,K21.9 - Gastro-esophageal reflux disease without esophagitis, **Date of Onset** :14/56/2024

Requested Investigations: 0195-107704-0801, CEFTRIAXONE-TABUK IV,2190-106618-1001, PARAFUSIV,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE,0005-174202-0781, RISEK 40MG,0188-135906-2441, PULMICORT,94640, AIRWAY INHALATION TREATMENT,85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,86140, C REACTIVE PROTEIN,96365, THER/PROPH/DIAG IV INF INIT,96372, THER/PROPH/DIAG INJ SC/IM,9, Consultation GP **Estimated Cost** :

Prescriptions: 0027-265802-1161 - (BUTAMIRATE DIHYDROGEN CITRATE : 0.15% W/V SYRUP,0252-185801-0391 - (DIPHENHYDRAMINE : 25 MG) (PARACETAMOL : 500 MG) (PSEUDOEPHEDRINE : 30 MG) FILM COATED TABLETS,0139-116206-1171 - (CLAVULANIC ACID : 125 MG) (AMOXICILLIN : 875 MG) TABLETS,0195-123701-0391 - (CETIRIZINE HCL : 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.

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 :** 14-Nov-2024

Signature : **Date** : 14-Nov-2024