

Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name

: ZEESHAN AHMAD AZIZ AHMAD

Card No

: I011-029-119743227-02

Policy Holder

: ZEESHAN AHMAD AZIZ AHMAD

Payer Name

: AL SAGR NATIONAL INSURANCE COMPANY

TPA

: E CARE - Blue Network

Validity

: 19-06-2024 To 18-06-2025

Gender

: Male

Date Of Birth

: 07-Jan-1990

Patient's Tel No

: 0561427224

Service Date

:14-Nov-2024

Health Provider

:CITICARE MEDICAL CENTER LLC

Doctor's Name

:AHSAN HUSSAIN

Co-Insurance

CONSULTATION	LAB/RADIOLOGY	PHYSIO	PHARMACY	IP	MATERNITY	DENTAL
10% max	NIL	NIL	NIL LIMIT	NIL	10%	NA

Network

: Green

Direct Access SP

: YES

Remarks

:

☐ 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

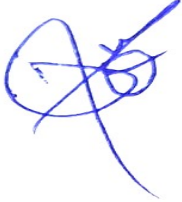
General Practitioner

DHA No: 87543658-001

CITICARE MEDICAL CENTER LLC

DUBAI - U.A.E.

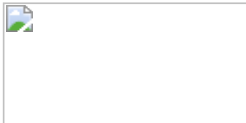
Signature



Date

: 14-Nov-2024

Patient 's signature{Parent : if minor}



Date

: Nov-2024