Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	: **MUHAMMAD ISMAIL HAFIZ ALLAH DITTA**	**Service Date**	**:16-Nov-2024**	**Network**	**:** Green
Card No	: **I011-029-120358189-02**	**Health Provider**	**:CITICARE MEDICAL CENTER LLC**		**Direct Access SP - YES**
Policy Holder	: **MUHAMMAD ISMAIL HAFIZ ALLAH DITTA**	**Doctor's Name**	**:AHSAN HUSSAIN**		
Payer Name	: **AL SAGR NATIONAL INSURANCE COMPANY**	**Remarks**	:		
TPA	: **E CARE - Blue Network**				
Validity	: **01-05-2024** To **30-04-2025**				
Gender	: **Male**				
Date Of Birth	: **01-Apr-1974**				
Patient's Tel No	: **0556740330**				

Co-Insurance :

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:

Clinical Findings:

Diagnosis: S90.811A - Abrasion, right foot, initial encounter,G89.11 - Acute pain due to trauma, **Date of Onset :**16/26/2024

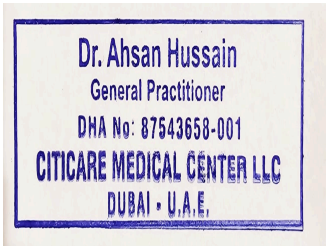
Requested Investigations: 9.01, Follow Up Consultation GP,51.01, Non-surgical cleansing with surgical dressing 16 sq inches / 100 sq centimeters or less **Estimated Cost :**

Prescriptions: **Estimated Cost :**

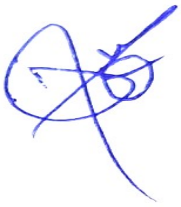
MEDICAL PRACTITIONER DECLARATION :

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.

Dr's Name : AHSAN HUSSAIN **Stamp :**



Signature :



Date : 16-Nov-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 : 16-Nov-2024