Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	: **MOHAMED BELAL ABDELAZIZ MAHMOUD SAAD**	**Service Date**	**:17-Dec-2024**
Card No	: **I040-029-118737797-01**	**Health Provider**	**:CITICARE MEDICAL CENTER LLC**
Policy Holder	: **MOHAMED BELAL ABDELAZIZ MAHMOUD SAAD**	**Doctor's Name**	**:AHSAN HUSSAIN**
Payer Name	: **UNION INSURANCE COMPANY**	**Co-Insurance**	:
TPA	: **E CARE - Blue Network**	**Remarks**	:
Validity	: **01-01-1900** To **01-01-2025**		
Gender	: **Male**		
Date Of Birth	: **12-Nov-1995**		
Patient's Tel No	: **0588943992**		

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: fever 16/12/2024 flu sore throat epigastric pain body pain **Duration :**

Vitals: Temp : 38.9 Bp :123 Pulse :110 Resp :18

Clinical Findings:

Diagnosis: J06.9 - Acute upper respiratory infection, unspecified,J00 - Acute nasopharyngitis [common cold],J20.9 - Acute bronchitis, unspecified,K21.9 - Gastro-esophageal reflux disease without esophagitis,M54.5 - Low back pain,E86.0 - Dehydration, **Date of Onset** :20/24/2024

Requested Investigations: 0195-107704-0801, CEFTRIAXONE-TABUK IV,2190-106618-1001, PARAFUSIV,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE,0005-174202-0781, RISEK 40MG,0102-152902-1001, LACTATED RINGERS INJECTION USP,96365, THER/PROPH/DIAG IV INF INIT,96372, THER/PROPH/DIAG INJ SC/IM,96360, HYDRATION IV INFUSION INIT,85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,86140, C REACTIVE PROTEIN,9, Consultation GP,96374, THER/PROPH/DIAG INJ IV PUSH **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 :

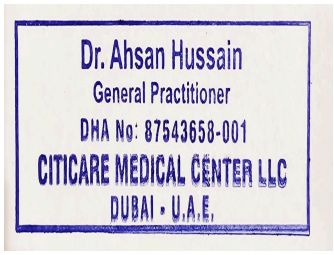
I declare that I am the patient's medical practitioner and that the particulars given are to the best of my knowledge true and correct.

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

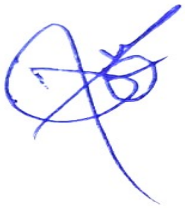
Stamp :



Patient 's signature{Parent : if minor}

Date : 20-Dec-2024

Signature :



Date : 20-Dec-2024