

Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name

MOHAMED BELAL

: ABDELAZIZ MAHMOUD SAAD

Card No

MOHAMED BELAL

: I040-029-118737797-01

Policy Holder

MOHAMED BELAL

: ABDELAZIZ MAHMOUD SAAD

Payer Name

UNION INSURANCE COMPANY

:

TPA

E CARE - Blue Network

:

Validity

01-01-1900 To 01-01-2025

:

Gender

Male

:

Date Of Birth

12-Nov-1995

:

Patient's Tel No

0588943992

:

Service Date

:17-Dec-2024

Health Provider

:CITICARE MEDICAL CENTER LLC

Doctor's Name

:AHSAN HUSSAIN

Co-Insurance

:

Network

: Green

Direct Access SP - YES

:

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

Remarks

:

☐ 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

:31/14/2024

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

:

Dr. Ahsan Hussain

General Practitioner

DHA No: 87543658-001

CITICARE MEDICAL CENTER LLC

DUBAI - U.A.E.

Signature

:



Date

:

31-Dec-2024

Patient 's signature{Parent : if minor}



Date

:

31-Dec-2024