Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	**: VISHAL KUMAR CHAUDHARY**	**Service Date**	**:23-Dec-2024** **Network** : Green
Card No	**: I011-029-119736610-02**	**Health Provider**	**:CITICARE MEDICAL CENTER LLC** **Direct Access SP - YES**
Policy Holder	**: VISHAL KUMAR CHAUDHARY**	**Doctor's Name**	**:Humaira**
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	**: 06-Aug-1993**		
Patient's Tel No	**: 0523004789**		

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 : c: fever flu sore throat cough 14 TH DEC. 2024 OE CHEST IS CONGESTED NO ADDED SOUNDS RESTLESS SMOKER **Duration:**

Vitals: Temp : 36.8 Bp :130 Pulse :76 Resp :18

Clinical Findings:

Diagnosis: J06.9 - Acute upper respiratory infection, unspecified,J20.9 - Acute bronchitis, unspecified,R05 - Cough,K29.00 - Acute gastritis without bleeding,R50.9 - Fever, unspecified, **Date of Onset** :27/55/2024

Requested Investigations: 0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE-(DEXAMETHASONE : 4 MG/ML) SOLUTION FOR INJECTION,0005-149902-1021, CLOFEN -(DICLOFENAC SODIUM : 75 MG/3ML) SOLUTION FOR INJECTION,96372, THER/PROPH/DIAG INJ SC/IM,96374, THER/PROPH/DIAG INJ IV PUSH,0188-135906-2441, PULMICORT-(BUDESONIDE : 0.5 MG/ML) SUSPENSION FOR NEBULIZATION,94640, AIRWAY INHALATION TREATMENT,INJ051, INJ-HYDROCORTISONE 100 MG/2ML,9.01, Follow Up Consultation GP **Estimated Cost** :

Prescriptions: 0005-119803-1171 - (PREDNISOLONE : 20 MG) TABLETS,6445-533801-1561 - (ESOMEPRAZOLE (AS MAGNESIUM : 20 MG DELAYED RELEASE CAPSULES,0195-123701-0391 - (CETIRIZINE HCL : 10 MG) FILM COATED TABLETS,0005-116702-2481 - (DIPHENHYDRAMINE : 12.5 MG/5ML SYRUP (SUGAR FREE, **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.

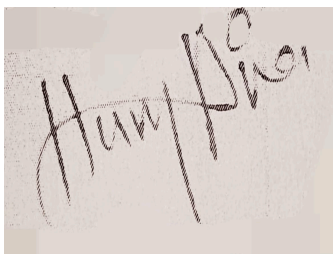
PATIENT'S DECLARATION :

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 : Humaira **Stamp :**

Dr. Humaira Mumtaz
General Practitioner
DHA No: 54155530-002
CITICARE MEDICAL CENTER LLC
DUBAI - U.A.E.

Patient 's signature{Parent if minor} : **Date :** 27-Dec-2024

Signature :  **Date** : 27-Dec-2024