

Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name

: VAJEER MOHAMMED DIVA

Card No

: I011-029-120069952-01

Policy Holder

: VAJEER MOHAMMED DIVA

Payer Name

: AL SAGR NATIONAL INSURANCE COMPANY

TPA

: E CARE - Blue Network

Validity

: 15-08-2024 To 14-08-2025

Gender

: Male

Date Of Birth

: 15-May-2001

Patient's Tel No

: 0543739900

Service Date

:12-Jan-2025

Health Provider

:CITICARE MEDICAL CENTER LLC

Doctor's Name

:Humaira

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

: co pain inthe finger of the foot due to accidently hit from the table 9 th jan. Duration: 2025 2 years back he had a fracture in the same finger oe no swelling chest is clear no added sounds restless

Vitals

:Temp : 36 Bp :156 Pulse :100 Resp :18

Clinical Findings

:

Diagnosis

: M62.838 - Other muscle spasm,R52 - Pain, unspecified,

Date of Onset

: 13/13/2025

Requested Investigations

: 9, Consultation GP

Estimated Cost

:

Prescriptions

: 2093-596002-0432 - (DICLOFENAC DIETHYLAMINE : 23.2 MG / G) GEL,0278-107903-0391 - (IBUPROFEN : 600 MG) FILM COATED TABLETS,1217-373201-2401 - (TOLPERISONE : 150 MG) SUGAR COATED TABLETS,

Estimated Cost

:

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

: Humaira

Stamp

:

Dr. Humaira Mumtaz

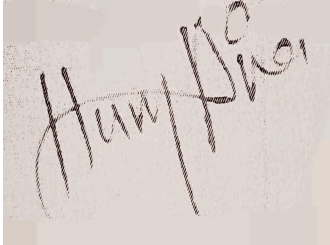
General Practitioner

DHA No: 54155530-002

CITICARE MEDICAL CENTER LLC

DUBAI - U.A.E.

Signature

:

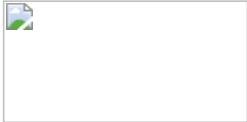
Date

: 13-Jan-2025

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

: Jan-2025