

Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name

MUHAMMAD ZAHEER BASHIR AHMAD

Card No

I011-029-120523178-02

Policy Holder

MUHAMMAD ZAHEER BASHIR AHMAD

Payer Name

AL SAGR NATIONAL INSURANCE COMPANY

TPA

E CARE - Blue Network

Validity

01-05-2024 To 30-04-2025

Gender

Male

Date Of Birth

26-Sep-1995

Patient's Tel No

565816252

Service Date

01-Feb-2025

Health Provider

CITICARE MEDICAL CENTER LLC

Doctor's Name

SANDIA

Co-Insurance

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

Remarks

Network

Green

Direct Access SP

YES

☐ Acute

☐ Pre-existing and chronic

☐ Maternity

Chief Complaints

pt c elevated bp tingling sensation in hands and weakness and dizziness and heavy head pt came to the clinc 2 days ago with same complain family history of HTN

Vitals:

Clinical Findings:

Diagnosis

R42 - Dizziness and giddiness,R03.0 - Elevated blood-pressure reading, w/o diagnosis of htn,E78.5 - Hyperlipidemia, unspecified,R51.9 - Headache, unspecified,E08.65 - Diabetes due to underlying condition w hyperglycemia,R34 - Anuria and oliguria,M54.5 - Low back pain,

Date of Onset

01/05/2025

Requested Investigations

80061, LIPID PANEL,80069, RENAL FUNCTION PANEL,9.01, Follow Up Consultation GP

Estimated Cost

Prescriptions

4884-220703-1171 - (TELMISARTAN : 20 MG 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.

Dr's Name

SANDIA

Stamp

Dr. Sandia Bhojwani
General Practitioner
DHA No: 65900212-001
PESHAWAR MEDICAL CENTER LLC
DUBAI - U.A.E.

Signature



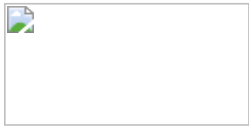
Date

01-Feb-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

01-Feb-2025