

Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name

: NADEEM AHMAD SALIM KHAN

Card No

: I011-029-119557476-02

Policy Holder

: NADEEM AHMAD SALIM KHAN

Payer Name

: AL SAGR NATIONAL INSURANCE COMPANY

TPA

: E CARE - Blue Network

Validity

: 19-06-2024 To 18-06-2025

Gender

: Male

Date Of Birth

: 20-Feb-1983

Patient's Tel No

: 0554951623

Service Date

:08-Mar-2025

Health Provider

:CITICARE MEDICAL CENTER LLC

Doctor's Name

:DR Amaizah

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

: pc : nasal blockage , sore throat , headache , all strated 08/03/25 o/e : hyperemic pahrynx chest congestd

Duration:

Vitals

:Temp : 36.2 Bp :120 Pulse :80 Resp :18

Clinical Findings:

Diagnosis

: J02.9 - Acute pharyngitis, unspecified,J45.991 - Cough variant asthma,J30.9 - Allergic rhinitis, unspecified,R50.9 - Fever, unspecified,R21 - Rash and other nonspecific skin eruption,

Date of Onset

:08/15/2025

Requested Investigations

: 85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,86140, C REACTIVE PROTEIN,0005-111805-1021, CHLOROHISTOL 10MG-(CHLORPHENIRAMINE MALEATE : 10 MG/ML) SOLUTION FOR INJECTION,94640, AIRWAY INHALATION TREATMENT,0188-135906-2441, PULMICORT-(BUDESONIDE : 0.5 MG/ML) SUSPENSION FOR NEBULIZATION,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE-(DEXAMETHASONE : 4 MG/ML) SOLUTION FOR INJECTION,96372, THER/PROPH/DIAG INJ SC/IM,9, Consultation GP

Estimated Cost

:

Prescriptions:

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

: DR Amaizah

Stamp

Dr. Amaizah Ishtiaq

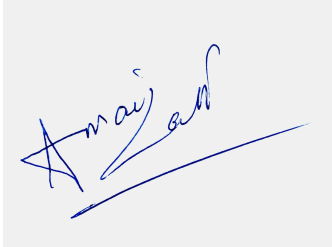
General Practitioner

DHA: 98486553-001

CITICARE MEDICAL CENTER

DUBAI - U.A.E

Signature



Date

: 08-Mar-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

: 08-Mar-2025