

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 :09-Mar-2025

Health Provider :CITICARE MEDICAL CENTER LLC

Doctor's Name :DR Amaizah

Co-Insurance

Remarks :

Network : Green

Direct Access SP - YES

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 : follow up

Duration :

Vitals:Temp : 36.9 Bp :160 Pulse :80 Resp :0

Clinical Findings:

Diagnosis: J02.9 - Acute pharyngitis, unspecified,R05 - Cough,R52 - Pain, unspecified,D50.9 - Iron deficiency anemia, unspecified,

Date of Onset :09/17/2025

Requested Investigations: 0005-111805-1021, CHLOROHISTOL 10MG,0005-149902-1021, CLOFEN ,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE,94640, AIRWAY INHALATION TREATMENT,0188-135906-2441, PULMICORT-(BUDESONIDE : 0.5 MG/ML) SUSPENSION FOR NEBULIZATION,96372, THER/PROPH/DIAG INJ SC/IM,9.01, Follow Up Consultation GP

Estimated : Cost

Prescriptions: 0005-116801-1162 - (SODIUM CITRATE : 57 MG/5ML) (AMMONIUM CHLORIDE : 131.5 MG/5 ML) (MENTHOL : 1.1 MG/5 ML) (DIPHENHYDRAMINE : 13.5 MG/5ML) SYRUP,2553-624901-0061 Cost - (IRON AS IRON PYROPHOSPHATE : 30 MG) (VITAMIN C : 120 MG) (PHOSPHATIDYLCHOLINE : 160 MG) (SOY LECITHIN : 50 MG) CAPSULES,

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 : DR Amaizah

Stamp :

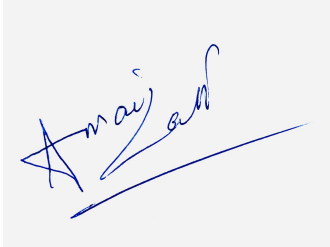
Dr. Amaizah Ishtiaq

General Practitioner

DHA: 98486553-001

CITICARE MEDICAL CENTER

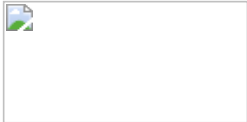
DUBAI - U.A.E

Signature :

Date : 09-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 : Mar-2025