

Administrative

MEDICAL CLAIM FORM

Claim Ref:

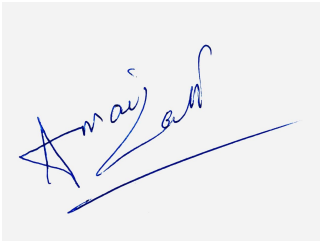
Patient Name : OMAIMA HOSNY SOLIMAN
MOHAMED ELTAIB
Card No : I011-029-122349787-01
Policy Holder : OMAIMA HOSNY SOLIMAN
MOHAMED ELTAIB
Payer Name : AL SAGR NATIONAL INSURANCE
COMPANY
TPA : E CARE - Blue Network
Validity : 01-08-2024 To 31-07-2025
Gender : Female
Date Of Birth : 21-Mar-1981
Patient's Tel No : 0544778170

Service Date : 18-Mar-2025 Network : Green
Health Provider : CITICARE MEDICAL CENTER LLC Direct Access SP - YES
Doctor's Name : DR Amaizah

Co-Insurance :

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

Remarks :

☐ Acute	☐ Pre-existing and chronic	☐ Maternity
Chief Complaints : pc : skin tag at anal area , on and off cauing itching and irritation low hb for long time o/e : look pale Duration:		
Vitals: Temp : 36.8 Bp :150 Pulse :78 Resp :18		
Clinical Findings:		
Diagnosis: R21 - Rash and other nonspecific skin eruption,D50.9 - Iron deficiency anemia, unspecified, Date of Onset : 18/40/2025		
Requested Investigations: 85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,86140, C REACTIVE PROTEIN,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE,0005-149902-1021, CLOFEN ,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.		
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 : DR Amaizah	Stamp : Dr. Amaizah Ishtiaq General Practitioner DHA: 98486553-001 CITICARE MEDICAL CENTER DUBAI - U.A.E	Patient 's signature{Parent : if minor}  Date : 18-Mar-2025
Signature : 	Date : 18-Mar-2025	