Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	: **OMAIMA HOSNY SOLIMAN MOHAMED ELTAIB**	**Service Date**	**:18-Mar-2025** **Network** : Green
Card No	: **I011-029-122349787-01**	**Health Provider**	**:CITICARE MEDICAL CENTER LLC** **Direct Access SP - YES**
Policy Holder	: **OMAIMA HOSNY SOLIMAN MOHAMED ELTAIB**	**Doctor's Name**	**:DR Amaizah**
Payer Name	: **AL SAGR NATIONAL INSURANCE COMPANY**	**Co-Insurance**	:
TPA	: **E CARE - Blue Network**		
Validity	: **01-08-2024** To **31-07-2025**		
Gender	: **Female**	**Remarks**	:
Date Of Birth	: **21-Mar-1981**		
Patient's Tel No	: **0544778170**		

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 : 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 :**

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