Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	: **MD SHER ALI GOLDAR MD MAHABUR RAHMAN GOLDER**	**Service Date**	**:24-Mar-2025** **Network** : Green
Card No	: **I005-029-119704077-01**	**Health Provider**	**:CITICARE MEDICAL CENTER LLC** **Direct Access SP - YES**
Policy Holder	: **MD SHER ALI GOLDAR MD MAHABUR RAHMAN GOLDER**	**Doctor's Name**	**:Humaira**
Payer Name	: **DUBAI INSURANCE COMPANY**	**Co-Insurance**	:
TPA	: **E CARE - Blue Network**	**Remarks**	:
Validity	: **08-08-2024** To **07-08-2025**		
Gender	: **Male**		
Date Of Birth	: **01-May-2001**		
Patient's Tel No	: **0523864580**		

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 : cough flu headache bodyache fever o/e hyperemia and chest congesion **Duration :**

Vitals: Temp : 38.1 Bp :119 Pulse :82 Resp :0

Clinical Findings:

Diagnosis: J06.9 - Acute upper respiratory infection, unspecified,R05 - Cough,M54.5 - Low back pain,R07.0 - Pain in throat, **Date of Onset** :24/01/2025

Requested Investigations: 2190-106618-1001, PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION,0005-149902-1021, CLOFEN ,96372, THER/PROPH/DIAG INJ SC/IM,85004, BLOOD COUNT AUTOMATED DIFFERENTIAL WBC COUNT,86140, C REACTIVE PROTEIN,9, Consultation GP,96365, THER/PROPH/DIAG IV INF INIT **Estimated Cost** :

Prescriptions: 0031-149904-1171 - (DICLOFENAC SODIUM : 50 MG) TABLETS,0006-106601-0393 - (PARACETAMOL : 500 MG) FILM COATED TABLETS,0097-127402-0391 - (AZITHROMYCIN : 250 MG) FILM COATED TABLETS,0320-148701-1171 - (LORATADINE : 10 MG TABLETS,0207-169703-1161 - (AMMONIUM CHLORIDE : N/A) (DIPHENHYDRAMINE : N/A) SYRUP, **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.

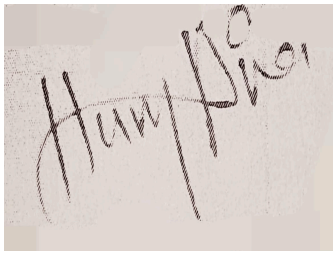
PATIENT'S DECLARATION :

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 : Humaira **Stamp :**

Dr. Humaira Mumtaz
General Practitioner
DHA No: 54155530-002
CITICARE MEDICAL CENTER LLC
DUBAI - U.A.E.

Patient 's signature{Parent if minor} : **Date :** 24-Mar-2025

Signature :  **Date** : 24-Mar-2025