Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	: **MUKESH KUMAR BANWARI LAL**	**Service Date:**	**25-Mar-2025**
Card No	: **I011-029-121106890-01**	**Health Provider**	**:CITICARE MEDICAL CENTER LLC**
Policy Holder	: **MUKESH KUMAR BANWARI LAL**	**Doctor's Name**	**:DR Amaizah**
Payer Name	: **AL SAGR NATIONAL INSURANCE COMPANY**	**Co-Insurance**	:
TPA	: **E CARE - Blue Network**	**Remarks**	:
Validity	: **21-10-2024** To **20-10-2025**		
Gender	: **Male**		
Date Of Birth	: **01-Jan-1993**		
Patient's Tel No	: **9715476161686**		

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 : pc : sneezing runny nose , pain in rib cage , and lower back stated 24/03/25 **Duration:**
o/e : look dehydrated , pale , lethargic tender rib cgae and lower back

Vitals: Temp : 36.3 Bp :120 Pulse :70 Resp :18

Clinical Findings:

Diagnosis: J30.9 - Allergic rhinitis, unspecified,R52 - Pain, unspecified,M54.5 - Low back pain,E86.0 - Dehydration, **Date of Onset:**25/17/2025

Requested Investigations: 0102-152902-1001, LACTATED RINGERS INJECTION USP,0005-149902-1021, CLOFEN ,0005-111805-1021, CHLOROHISTOL 10MG,96372, THER/PROPH/DIAG INJ SC/IM,0248-122107-1021, DEXAMETHASONE SODIUM PHOSPHATE,96360, HYDRATION IV INFUSION INIT,85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,9, Consultation GP **Estimated Cost** :

Prescriptions: 0005-119805-1172 - (PREDNISOLONE : 5 MG) TABLETS,2150-575201-1171 - (CALCIUM : 400 MG) (VITAMIN D3 : 200 IU) (MAGNESIUM : 100 MG) (ZINC : 4 MG) TABLETS,0195-123701-0391 - (CETIRIZINE HCL : 10 MG FILM COATED TABLETS,0027-149906-1171 - (DICLOFENAC SODIUM : 25 MG) TABLETS, **Estimated Cost** :

MEDICAL PRACTITIONER DECLARATION :

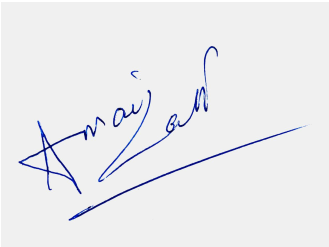
I declare that I am the patient's medical practitioner and that the particulars given are to the best of my knowledge true and correct.

Dr's Name : DR Amaizah

Stamp :

Dr. Amaizah Ishtiaq
General Practitioner
DHA: 98486553-001
CITICARE MEDICAL CENTER
DUBAI - U.A.E

Signature :



Date : 25-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 : 25-Mar-2025