Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	: **ZEESHAN UMAR MUHAMMAD SALEEM**	**Service Date**	:**04-Apr-2025** **Network** : Green
Card No	: **I005-029-122019489-01**	**Health Provider**	:**CITICARE MEDICAL CENTER LLC** **Direct Access SP - YES**
Policy Holder	: **ZEESHAN UMAR MUHAMMAD SALEEM**	**Doctor's Name**	:**DR Amaizah**
Payer Name	: **DUBAI INSURANCE COMPANY**	**Co-Insurance**	:
TPA	: **E CARE - Blue Network**	**Remarks**	:
Validity	: **09-01-2025** To **14-10-2025**		
Gender	: **Male**		
Date Of Birth	: **17-Jan-1996**		
Patient's Tel No	: **971508601975**		

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 : PAIN AND SWELLING ON CHEST , ASSOCIATED WITH DISCOMFORT CAUING SLEEP DISTURBES O/E : FOLLICLUITS **Duration:**

Vitals:

Clinical Findings:

Diagnosis: R21 - Rash and other nonspecific skin eruption,R52 - Pain, unspecified,L03.90 - Cellulitis, unspecified,R50.9 - Fever, unspecified,R73.9 - Hyperglycemia, unspecified, **Date of Onset** :04/37/2025

Requested Investigations: 85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,86140, C REACTIVE PROTEIN,82947, GLUCOSE QUANTITATIVE BLOOD XCPT REAGENT STRIP,0195-107704-0802, CEFTRIAXONE-TABUK IM,0005-149902-1021, CLOFEN ,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE,96372, THER/PROPH/DIAG INJ SC/IM,2190-106618-1001, PARAFUSIV,96374, THER/PROPH/DIAG INJ IV PUSH,9, Consultation GP **Estimated Cost** :

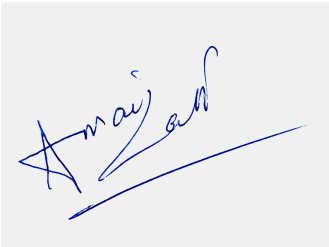
Prescriptions: 0027-149906-1171 - (DICLOFENAC SODIUM : 25 MG) TABLETS,6603-159502-1171 - (SERRATIOPEPTIDASE : 10 MG) TABLETS,0397-116207-0391 - (AMOXICILLIN : 500 MG) (CLAVULANIC ACID : 125 MG) FILM COATED TABLETS,0031-187502-0151 - (BETAMETHASONE : 0.10%) (FUSIDIC ACID : 2%) CREAM, **Estimated Cost** :

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** : 04-Apr-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 :** 04-Apr-2025