

Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name

: SABIN THOMAS SAVARI MUTHU SAVARI MUTHU

Card No

: I005-029-118022667-01

Policy Holder

: SABIN THOMAS SAVARI MUTHU SAVARI MUTHU

Payer Name

: DUBAI INSURANCE COMPANY

TPA

: E CARE - Blue Network

Validity

: 08-08-2024 To 07-08-2025

Gender

: Male

Date Of Birth

: 30-Jan-1994

Patient's Tel No

: 0525756462

Service Date

:04-Apr-2025

Health Provider

:CITICARE MEDICAL CENTER LLC

Doctor's Name

:DR Amaizah

Co-Insurance

Network

: Green

Direct Access SP - YES

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 : SORE THROAT , BODYPAIN , HEDACHE , BURNING IN NSAL MUCOSA STARTED 03/04/25 O/E : LOOK DEHYDRATED , IRRITAB;E HYPEREMIC PHARYNX CHEST CONGESTED

Duration:

Vitals

:Temp : 36.8 Bp :120 Pulse :74 Resp :18

Clinical Findings:

Diagnosis:

J06.9 - Acute upper respiratory infection, unspecified,R50.9 - Fever, unspecified,R09.81 - Nasal congestion,R06.2 - Wheezing,R05 - Cough,

Date of Onset

:04/11/2025

Requested Investigations:

85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,86140, C REACTIVE PROTEIN,0005-111805-1021, CHLOROHISTOL 10MG,0195-107704-0802, CEFTRIAXONE-TABUK IM,94640, AIRWAY INHALATION TREATMENT,0188-135906-2441, PULMICORT,9, Consultation GP,96372, THER/PROPH/DIAG INJ SC/IM

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.

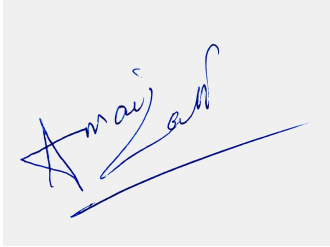
Dr's Name

: 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

: Apr-2025