Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	: **SABIN THOMAS SAVARI MUTHU SAVARI MUTHU**	**Service Date**	**:04-Apr-2025** **Network** : Green
Card No	: **I005-029-118022667-01**	**Health Provider**	**:CITICARE MEDICAL CENTER LLC** **Direct Access SP - YES**
Policy Holder	: **SABIN THOMAS SAVARI MUTHU SAVARI MUTHU**	**Doctor's Name**	**:DR Amaizah**
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	: **30-Jan-1994**		
Patient's Tel No	: **0525756462**		

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 : 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** :04/18/2025

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,2190-106618-1001, PARAFUSIV,96360, HYDRATION IV INFUSION INIT,96365, THER/PROPH/DIAG IV INF INIT **Estimated Cost** :

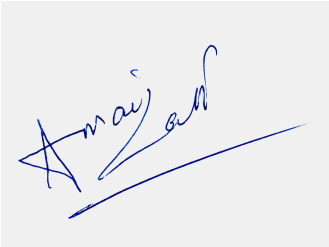
Prescriptions: 0006-106601-0394 - (PARACETAMOL : 500 MG) FILM COATED TABLETS,0027-296201-1971 - (XYLOMETAZOLINE HCL (MENTHOL) : 0.1%) LIQUID FOR SPRAY (NASAL),0397-116207-0391 - (AMOXICILLIN : 500 MG) (CLAVULANIC ACID : 125 MG) FILM COATED TABLETS,0195-123701-0391 - (CETIRIZINE HCL : 10 MG) FILM COATED 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** : 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