Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	**: MARIANA DEEB ASSAF**	**Service Date**	**:09-Apr-2025** **Network** : Green
Card No	**: I011-029-121862988-01**	**Health Provider**	**:CITICARE MEDICAL CENTER LLC** **Direct Access SP - YES**
Policy Holder	**: MARIANA DEEB ASSAF**	**Doctor's Name**	**:Humaira**
Payer Name	**: AL SAGR NATIONAL INSURANCE COMPANY**	**Co-Insurance**	:
TPA	**: E CARE - Blue Network**	**Remarks**	:
Validity	**: 01-04-2025** To **31-03-2026**		
Gender	**: Female**		
Date Of Birth	**: 30-Jan-1995**		
Patient's Tel No	**: 0563302740**		

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 : productive cough with yellow sputum sore throat head and body aches flu runny nose nasal congesion weakness o/e hyperemia and chest congesion **Duration:**

Vitals: Temp : 36.8 Bp :112 Pulse :81 Resp :0

Clinical Findings:

Diagnosis: J02.9 - Acute pharyngitis, unspecified,R09.81 - Nasal congestion,R05 - Cough,R07.0 - Pain in throat, **Date of Onset :**09/28/2025

Requested Investigations: 85027, BLOOD COUNT COMPLETE AUTOMATED,86140, C REACTIVE PROTEIN,0188-135906-2441, PULMICORT,0195-107704-0801, CEFTRIAXONE-TABUK IV,0248-122107-1021, DEXAMETHASONE SODIUM PHOSPHATE,0439-152905-1001, LACTATED RINGERS INJECTION USP,96365, THER/PROPH/DIAG IV INF INIT,9, Consultation GP,96372, THER/PROPH/DIAG INJ SC/IM,94640, AIRWAY INHALATION TREATMENT **Estimated Cost :**

Prescriptions: 1162-414202-2091 - (PARACETAMOL : 600 MG) (PHENYLEPHRINE HCL : 10 MG) ORAL POWDER,0397-116207-0391 - (AMOXICILLIN : 500 MG) (CLAVULANIC ACID : 125 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.

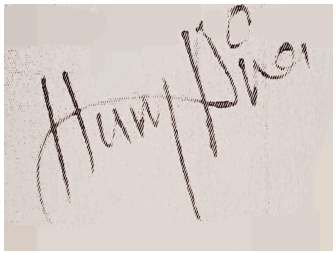
PATIENT'S DECLARATION :

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 :** 09-Apr-2025

Signature :  **Date** : 09-Apr-2025