

Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name : ZEESHAN UMAR MUHAMMAD SALEEM

Card No : I005-029-122019489-01

Policy Holder : ZEESHAN UMAR MUHAMMAD SALEEM

Payer Name : DUBAI INSURANCE COMPANY

TPA : E CARE - Blue Network

Validity : 09-01-2025 To 14-10-2025

Gender : Male

Date Of Birth : 17-Jan-1996

Patient's Tel No : 971508601975

Service Date :12-Apr-2025

Health Provider :CITICARE MEDICAL CENTER LLC

Doctor's Name :DR Amaizah

Co-Insurance :

CONSULTATION	LAB/RADIOLOGY	PHYSIO	PHARMACY	IP	MATERNITY	DENTAL
10% max	NIL	NIL	NIL LIMIT	NIL	10%	NA

Remarks :

Network : Green

Direct Access SP - YES

☐ Acute

☐ Pre-existing and chronic

☐ Maternity

Chief Complaints : pc ; boil on chest presented on 04/04/25 antibiotics oral an topical were started not responding to traetment needs incision and draingae

Duration:

Vitals:Temp : 37.1 Bp :150 Pulse :76 Resp :18

Clinical Findings:

Diagnosis: R21 - Rash and other nonspecific skin eruption,L02.91 - Cutaneous abscess, unspecified,R52 - Pain, unspecified,

Date of Onset :12/13/2025

Requested Investigations: 10061, INCISION&DRAINAGE ABSCESS COMPLICATED/MULTIPLE,0005-149902-1021, CLOFEN ,0248-122107-1021, DEXAMETHASONE SODIUM PHOSPHATE,0195-107704-0802, CEFTRIAXONE-TABUK IM,96372, THER/PROPH/DIAG INJ SC/IM

Estimated Cost :

Prescriptions:

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 :

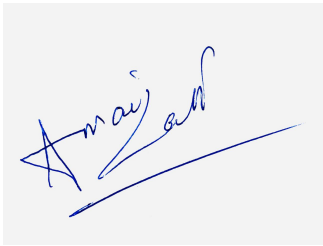
Dr. Amaizah Ishtiaq

General Practitioner

DHA: 98486553-001

CITICARE MEDICAL CENTER

DUBAI - U.A.E

Signature :

Date : 12-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