

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 : 13-Apr-2025

Health Provider : CITICARE MEDICAL CENTER LLC

Doctor's Name : DR Amaizah

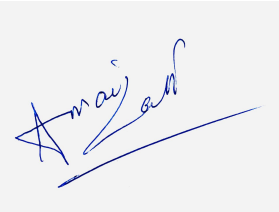
Co-Insurance :

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

Network : Green

Direct Access SP - YES

Remarks :

☐ Acute	☐ Pre-existing and chronic	☐ Maternity
Chief Complaints : Duration :		
Vitals: Temp : 36.4 Bp : 130 Pulse : 76 Resp : 18		
Clinical Findings:		
Diagnosis: L02.91 - Cutaneous abscess, unspecified, R52 - Pain, unspecified, R50.9 - Fever, unspecified, Date of Onset : 13/19/2025		
Requested Investigations: 51.03, Non-surgical cleansing with surgical dressing more than 48 sq inches / 300 sq centimeters, 0005-149902-1021, CLOFEN , 0195-107704-0802, CEFTRIAXONE-TABUK IM, 96372, THER/PROPH/DIAG INJ SC/IM, 9.01, Follow Up Consultation GP, 0195-107704-0801, CEFTRIAXONE-TABUK 1 GM IV, 96365, THER/PROPH/DIAG IV INF INIT		
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.		
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 : DR Amaizah	Stamp : Dr. Amaizah Ishtiaq General Practitioner DHA: 98486553-001 CITICARE MEDICAL CENTER DUBAI - U.A.E	Patient's signature {Parent : if minor}  13-Apr-2025
Signature : 	Date : 13-Apr-2025	