Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	: **ZEESHAN UMAR MUHAMMAD SALEEM**	**Service Date**	:**13-Apr-2025** **Network** : Green
Card No	: **I005-029-122019489-01**	**Health Provider**	:**CITICARE MEDICAL CENTER LLC** **Direct Access SP - YES**
Policy Holder	: **ZEESHAN UMAR MUHAMMAD SALEEM**	**Doctor's Name**	:**DR Amaizah**
Payer Name	: **DUBAI INSURANCE COMPANY**	**Co-Insurance**	:
TPA	: **E CARE - Blue Network**	**Remarks**	:
Validity	: **09-01-2025** To **14-10-2025**		
Gender	: **Male**		
Date Of Birth	: **17-Jan-1996**		
Patient's Tel No	: **971508601975**		

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 : **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: **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 : DR Amaizah **Stamp :**

Dr. Amaizah Ishtiaq
General Practitioner
DHA: 98486553-001
CITICARE MEDICAL CENTER
DUBAI - U.A.E

Patient 's signature{Parent if minor} : **Date** : 13-Apr-2025

Signature : **Date** : 13-Apr-2025