Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	: **HANI DIAB ISMAIL HAMMAD**	**Service Date**	:**15-Apr-2025** **Network** : Green
Card No	: **I011-029-120604809-01**	**Health Provider**	:**CITICARE MEDICAL CENTER LLC** **Direct Access SP - YES**
Policy Holder	: **HANI DIAB ISMAIL HAMMAD**	**Doctor's Name**	:**DR Amaizah**
Payer Name	: **AL SAGR NATIONAL INSURANCE COMPANY**	**Co-Insurance**	:
TPA	: **E CARE - Green Network**	**Remarks**	:
Validity	: **17-08-2024** To **16-08-2025**		
Gender	: **Male**		
Date Of Birth	: **28-Nov-1978**		
Patient's Tel No	: **0558244454**		

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 : lethargy , low energy , bodypain , muscle sorenes all strated week ago bp is elevated **Duration:**

Vitals: Temp : 37.4 Bp :140 Pulse :86 Resp :18

Clinical Findings:

Diagnosis: R53.1 - Weakness,R52 - Pain, unspecified, **Date of Onset** : 15/47/2025

Estimated Cost :

Requested Investigations: 2, BASIC WELLNESS PANEL,9, Consultation GP

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} : **Date** : 15-Apr-2025

Signature : **Date** : 15-Apr-2025