Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	: **AZHAR MEHMOOD KHAN MUHAMMAD SAFDAR KHAN**	**Service Date**	**:22-Apr-2025**	**Network**	: Green
Card No	: **i011-029-118340965-01**	**Health Provider**	**:CITICARE MEDICAL CENTER LLC**	**Direct Access SP - YES**	
Policy Holder	: **AZHAR MEHMOOD KHAN MUHAMMAD SAFDAR KHAN**	**Doctor's Name**	**:DR Amaizah**		
Payer Name	: **AL SAGR NATIONAL INSURANCE COMPANY**	**Co-Insurance**	:		
TPA	: **E CARE - Blue Network**				
Validity	: **20-02-2025** To **20-02-2026**	**Remarks**	:		
Gender	: **Male**				
Date Of Birth	: **21-Dec-1987**				
Patient's Tel No	: **0563776456**				

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 : severe sore throat ,bodypain , fever which is high grade started ,21/4/25 **Duration:**
took pnadol not improved o/e : look irritable due to fever hypemic pharynx tonsils are swolen
chest congested

Vitals: Temp : 382 Bp :130 Pulse :88 Resp :18

Clinical Findings:

Diagnosis: J03.90 - Acute tonsillitis, unspecified,R05 - Cough,R50.9 - Fever, unspecified,E86.0 - Dehydration,R11.2 - Nausea with vomiting, unspecified, **Date of Onset** :22/13/2025

Requested Investigations: 0195-107704-0802, CEFTRIAXONE-TABUK IM,2190-106618-1001, PARAFUSIV,0005-149902-1021, CLOFEN ,85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,86140, C REACTIVE PROTEIN,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE,96360, HYDRATION IV INFUSION INIT,0439-152905-1001, LACTATED RINGERS INJECTION USP,96372, THER/PROPH/DIAG INJ SC/IM,9, Consultation GP,96365, THER/PROPH/DIAG IV INF INIT **Estimated Cost** :

Prescriptions: 0397-116207-0391 - (AMOXICILLIN : 500 MG) (CLAVULANIC ACID : 125 MG) FILM COATED TABLETS,0195-123701-0391 - (CETIRIZINE HCL : 10 MG) FILM COATED TABLETS, **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 :** 22-Apr-2025

Signature : **Date** : 22-Apr-2025