Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	**: SAMPATH PRASANNA KUMARA MALAGODA GAMAGE**	**Service Date**	**:25-Apr-2025**
Card No	**: I005-029-113837921-04**	**Health Provider**	**:CITICARE MEDICAL CENTER LLC**
Policy Holder	**: SAMPATH PRASANNA KUMARA MALAGODA GAMAGE**	**Doctor's Name**	**:Dr.Farhan Iyas**
Payer Name	**: DUBAI INSURANCE COMPANY**	**Co-Insurance**	:
TPA	**: E CARE - Green Network**	**Remarks**	**:**
Validity	**: 17-01-2025** To **16-01-2026**		
Gender	**: Male**		
Date Of Birth	**: 24-Oct-1973**		
Patient's Tel No	**: 0505503947**		

Network : Green

Direct Access SP - YES

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 : high grade fever cough dry headache bodyaches sore throat o/e hyperemia and chest congesion **Duration:**

Vitals: Temp : 38.4 Bp :140 Pulse :99 Resp :0

Clinical Findings:

Diagnosis: J06.9 - Acute upper respiratory infection, unspecified,R05 - Cough,R50.9 - Fever, unspecified,R52 - Pain, unspecified,R09.81 - Nasal congestion, **Date of Onset** :25/10/2025

Requested Investigations: 2190-106618-1001, PARAFUSIV,96365, THER/PROPH/DIAG IV INF INIT,85004, BLOOD COUNT AUTOMATED DIFFERENTIAL WBC COUNT,86140, C REACTIVE PROTEIN,9, Consultation GP **Estimated Cost** :

Prescriptions: 1162-414202-2091 - (PARACETAMOL : 600 MG) (PHENYLEPHRINE HCL : 10 MG) ORAL POWDER,0397-116207-0391 - (AMOXICILLIN : 500 MG) (CLAVULANIC ACID : 125 MG) FILM COATED TABLETS,0320-148701-1171 - (LORATADINE : 10 MG) TABLETS,0027-265802-1161 - (BUTAMIRATE DIHYDROGEN CITRATE : 0.15% W/V) SYRUP, **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.

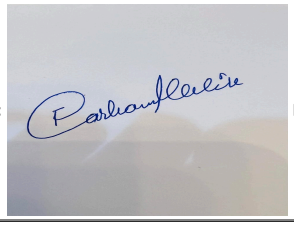
PATIENT'S DECLARATION :

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.Farhan Iyas **Stamp :**

Dr .Frahan Ilyas Malik
Physician-General Practitioner
DHA-06441782-001
CITICARE MEDICAL CENTER
DUBAI U.A.E

Patient 's signature{Parent if minor} : **Date :** 25-Apr-2025

Signature :  **Date** : 25-Apr-2025