Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	: **MA RUBIETHA SOBERANO ALPES**	**Service Date:**	**30-Apr-2025** **Network** : Green
Card No	: **I020-029-119436583-03**	**Health Provider**	**:CITICARE MEDICAL CENTER LLC** **Direct Access SP - YES**
Policy Holder	: **MA RUBIETHA SOBERANO ALPES**	**Doctor's Name**	**:DR Amaizah**
Payer Name	: **AL-BUHAIRA NATIONAL INSURANCE COMPANY**	**Co-Insurance**	:
TPA	: **E CARE - Green Network**	**Remarks**	:
Validity	: **01-02-2025** To **31-01-2026**		
Gender	: **Female**		
Date Of Birth	: **01-Jan-1984**		
Patient's Tel No	: **509412509**		

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 : sore throat , bodypain , and sneezing and low grade fever , started 28/04/25 o/e : looking lethargic o/e : tonsilsl are enlarged **Duration:**

Vitals: Temp : 37.4 Bp :170 Pulse :102 Resp :18

Clinical Findings:

Diagnosis: J03.90 - Acute tonsillitis, unspecified,J30.9 - Allergic rhinitis, unspecified,R50.9 - Fever, unspecified, **Date of Onset :**30/31/2025

Requested Investigations: 94640, AIRWAY INHALATION TREATMENT,0188-135906-2441, PULMICORT,85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,86140, C REACTIVE PROTEIN,0195-107704-0802, CEFTRIAXONE-TABUK IM,0005-111805-1021, CHLOROHISTOL 10MG,96372, THER/PROPH/DIAG INJ SC/IM,2190-106618-1001, PARAFUSIV,INJ064, VITAMIN D, INJECTION ,INJ014, INJ-NEUROBION VITAMIN B GROUPS,96372, INJECTION SERVICE-IM,2, BASIC WELLNESS PANEL,9, Consultation GP **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.

Dr's Name : DR Amaizah **Stamp :**

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

Signature : **Date** : 30-Apr-2025

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.

Patient 's signature{Parent if minor} : **Date :** 30-Apr-2025