Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	: **SULITHA UDAYAKUMARA DE SILVA MAHADURA**	**Service Date**	**:30-Apr-2025**	**Network**	: Green
Card No	: **I011-029-122219203-01**	**Health Provider**	**:CITICARE MEDICAL CENTER LLC**	**Direct Access SP - YES**	
Policy Holder	: **SULITHA UDAYAKUMARA DE SILVA MAHADURA**	**Doctor's Name**	**:Dr.Farhan Iyas**		
Payer Name	: **AL SAGR NATIONAL INSURANCE COMPANY**	**Co-Insurance**	:		
TPA	: **E CARE - Blue Network**				
Validity	: **20-02-2025** To **19-02-2026**	**Remarks**	:		
Gender	: **Male**				
Date Of Birth	: **04-Jul-1987**				
Patient's Tel No	: **0509709358**				

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 : dry cough sore throat headache body ache fever started yesterday o/e hyperemia and chest congestion **Duration:**

Vitals: Temp : 37.8 Bp :134 Pulse :82 Resp :18

Clinical Findings:

Diagnosis: J06.9 - Acute upper respiratory infection, unspecified,R50.9 - Fever, unspecified,R07.0 - Pain in throat,R51.9 - Headache, unspecified,R09.81 - Nasal congestion, **Date of Onset** :30/46/2025

Requested Investigations: 2190-106618-1001, PARAFUSIV,96365, THER/PROPH/DIAG IV INF INIT,0005-149902-1021, CLOFEN ,96372, THER/PROPH/DIAG INJ SC/IM,0188-135906-2441, PULMICORT,85004, BLOOD COUNT AUTOMATED DIFFERENTIAL WBC COUNT,86140, C REACTIVE PROTEIN **Estimated Cost** :

Prescriptions: 1162-414202-2091 - (PARACETAMOL : 600 MG) (PHENYLEPHRINE HCL : 10 MG) ORAL POWDER,0320-148701-1171 - (LORATADINE : 10 MG) TABLETS,0397-116207-0391 - (AMOXICILLIN : 500 MG) (CLAVULANIC ACID : 125 MG) FILM COATED 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.

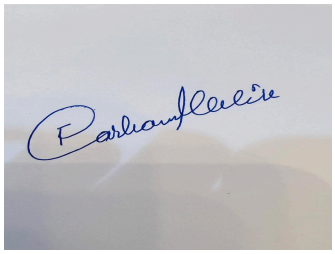
PATIENT'S DECLARATION :

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** : 30-Apr-2025

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