Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	**: POLA WAGDY FAHIM**
Card No	**: I011-029-118504990-01**
Policy Holder	**: POLA WAGDY FAHIM**
Payer Name	**: AL SAGR NATIONAL INSURANCE COMPANY**
TPA	**: E CARE - Blue Network**
Validity	**: 04-09-2024** To **03-09-2025**
Gender	**: Male**
Date Of Birth	**: 02-Jul-1997**
Patient's Tel No	**: 0504122610**

Service Date :**30-Apr-2025** **Network** : Green

Health Provider :**CITICARE MEDICAL CENTER LLC** **Direct Access SP - YES**

Doctor's Name :**Dr.Farhan Iyas**

Co-Insurance :

CONSULTATION	LAB/RADIOLOGY	PHYSIO	PHARMACY	IP	MATERNITY	DENTAL
10% max	NIL	NIL	NIL LIMIT	NIL	10%	NA

Remarks :

☐ **Acute** ☐ **Pre-existing and chronic** ☐ **Maternity**

Chief Complaints : productive cough sore throat weakness sputum coming out nasal congestion **Duration:**
body ache o/e hypermia and chest congestion

Vitals: Temp : 36 Bp :129 Pulse :84 Resp :18

Clinical Findings:

Diagnosis: J06.9 - Acute upper respiratory infection, unspecified,R05 - Cough,R09.81 - Nasal congestion,R52 - Pain, unspecified,R53.1 - Weakness, **Date of Onset** :30/01/2025

Requested Investigations: 0188-135906-2441, PULMICORT,85027, BLOOD COUNT COMPLETE AUTOMATED,86140, C REACTIVE PROTEIN,0195-107704-0801, CEFTRIAXONE-TABUK IV,96365, IV INFUSION THERAPY -Antibiotics & Others,0439-152905-1001, LACTATED RINGERS INJECTION USP,INJ008, INJ-DEXAMETHASONE 4 MG/2ML,9, Consultation GP,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE,96360, HYDRATION IV INFUSION INIT,0439-152905-1001, LACTATED RINGERS INJECTION USP,0195-107704-0801, CEFTRIAXONE-TABUK IV,96365, THER/PROPH/DIAG IV INF INIT,96372, THER/PROPH/DIAG INJ SC/IM,0005-149902-1021, CLOFEN **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.

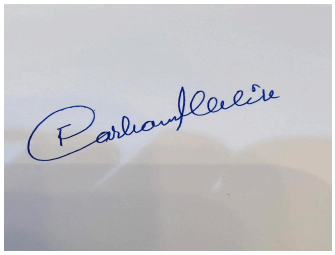
PATIENT'S DECLARATION :

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 :** 30-Apr-2025

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