Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	: **DIMUTHU PRIYANKA DE SILVA KUDA VIDANALAGE**	**Service Date**	**:02-May-2025** **Network** : Green
Card No	: **I011-029-120997885-01**	**Health Provider**	**:CITICARE MEDICAL CENTER LLC** **Direct Access SP - YES**
Policy Holder	: **DIMUTHU PRIYANKA DE SILVA KUDA VIDANALAGE**	**Doctor's Name**	**:Dr.Farhan Iyas**
Payer Name	: **AL SAGR NATIONAL INSURANCE COMPANY**	**Co-Insurance**	:
TPA	: **E CARE - Blue Network**	**Remarks**	:
Validity	: **20-02-2025** To **19-02-2026**		
Gender	: **Female**		
Date Of Birth	: **26-Dec-1976**		
Patient's Tel No	: **0567334231**		

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 low blood pressure cough headache body pain sore throat started yesterday o/e chest congesion and hyperemia **Duration:**

Vitals: Temp : 40 Bp :107 Pulse :86 Resp :18

Clinical Findings:

Diagnosis: J06.9 - Acute upper respiratory infection, unspecified,R50.9 - Fever, unspecified,R52 - Pain, unspecified,R05 - Cough, **Date of Onset** :02/15/2025

Requested Investigations: 2190-106618-1001, PARAFUSIV,96365, THER/PROPH/DIAG IV INF INIT,0005-149902-1021, CLOFEN ,96372, THER/PROPH/DIAG INJ SC/IM,85027, BLOOD COUNT COMPLETE AUTOMATED,86140, C REACTIVE PROTEIN,9, Consultation GP **Estimated Cost** :

Prescriptions: 0097-142201-0391 - (DICLOFENAC POTASSIUM : 50 MG) FILM COATED TABLETS,0397-116207-0391 - (AMOXICILLIN : 500 MG) (CLAVULANIC ACID : 125 MG) FILM COATED TABLETS,0320-148701-1171 - (LORATADINE : 10 MG) TABLETS,0006-346601-0051 - (PHENYLEPHRINE (SYSTEMIC) : N/A) (CAFFEINE : N/A) (PARACETAMOL : N/A) CAPLETS, **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.

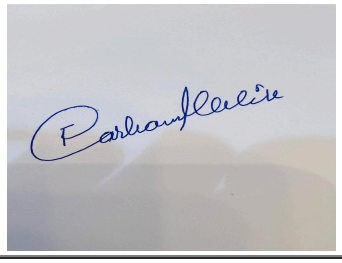
PATIENT'S DECLARATION :

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** : 02-May-2025

Signature :  **Date** : 02-May-2025