Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	**: POLA WAGDY FAHIM**	**Service Date**	**:06-May-2025** **Network** : Green
Card No	**: I011-029-118504990-01**	**Health Provider**	**:CITICARE MEDICAL CENTER LLC** **Direct Access SP - YES**
Policy Holder	**: POLA WAGDY FAHIM**	**Doctor's Name**	**:AISHA**
Payer Name	**: AL SAGR NATIONAL INSURANCE COMPANY**	**Co-Insurance**	:
TPA	**: E CARE - Blue Network**	**Remarks**	:
Validity	**: 04-09-2024** To **03-09-2025**		
Gender	**: Male**		
Date Of Birth	**: 02-Jul-1997**		
Patient's Tel No	**: 0504122610**		

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 : productive cough sore throat weakness sputum coming out high crp 1st dose iv antibiotic given **Duration:**

Vitals: Temp : 37 Bp :136 Pulse :84 Resp :18

Clinical Findings:

Diagnosis: J06.9 - Acute upper respiratory infection, unspecified,R05 - Cough,R06.2 - Wheezing, **Date of Onset :**06/25/2025

Requested Investigations: 0188-135906-2441, PULMICORT-(BUDESONIDE : 0.5 MG/ML) SUSPENSION FOR NEBULIZATION,94640, AIRWAY INHALATION TREATMENT,0195-107704-0801, CEFTRIAXONE-TABUK IV,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE-(DEXAMETHASONE : 4 MG/ML) SOLUTION FOR INJECTION,96372, THER/PROPH/DIAG INJ SC/IM,9, Consultation GP,96360, HYDRATION IV INFUSION INIT **Estimated Cost :**

Prescriptions: 2027-719101-0392 - (PARACETAMOL : 500 MG) (IBUPROFEN : 150 MG) (PHENYLEPHRINE HCL : 2.5 MG) FILM COATED TABLETS,0186-143702-0061 - (CELECOXIB : 100 MG) CAPSULES,1393-135904-2441 - (BUDESONIDE : 0.5 MG/2ML) SUSPENSION FOR NEBULIZATION, **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 : AISHA **Stamp :**

Dr. Aisha Umer
Physician- General Practitioner
DHA- 40131439-002
CITICARE MEDICAL CENTER
DUBAI - U.A.E

Patient 's signature{Parent : if minor} **Date :** 06-May-2025

Signature : **Date :** 06-May-2025