Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name : Ramesh Kumar
Card No : I011-029-120467737-02
Policy Holder : Ramesh Kumar
Payer Name : AL SAGR NATIONAL INSURANCE COMPANY
TPA : E CARE - Blue Network
Validity : 19-06-2024 To 18-06-2025
Gender : Male
Date Of Birth : 05-Jan-1997
Patient's Tel No : 0545766439

Service Date :12-May-2025 **Network** : Green
Health Provider :CITICARE MEDICAL CENTER LLC **Direct Access SP - YES**
Doctor's Name :DR Amaizah
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 : pc : vomitting 8 episodes , abdomal pain , and weakness , epigastric pain and low grade fever , started 11/05/25 o/e : look pale , lethargic ,look dehydrated tendr epigstric region **Duration:**

Vitals: Temp : 36 Bp :124 Pulse :76 Resp :18

Clinical Findings:

Diagnosis: R11.2 - Nausea with vomiting, unspecified,E86.0 - Dehydration,K29.00 - Acute gastritis without bleeding,R50.9 - Fever, unspecified,A09 - Infectious gastroenteritis and colitis, unspecified, **Date of Onset** :12/49/2025

Requested Investigations: 0439-152905-1001, LACTATED RINGERS INJECTION USP,0005-150403-1021, PREMOSAN -(METOCLOPRAMIDE : 10 MG/2ML) SOLUTION FOR INJECTION,0005-174202-0781, RISEK 40MG,96372, THER/PROPH/DIAG INJ SC/IM,0195-107704-0802, CEFTRIAXONE-TABUK IM,96360, HYDRATION IV INFUSION INIT,9, Consultation GP,96374, THER/PROPH/DIAG INJ IV PUSH **Estimated Cost** :

Prescriptions: 2027-560101-0392 - (IBUPROFEN : 150 MG) (PARACETAMOL : 500 MG) FILM COATED TABLETS,6619-608703-0831 - (SODIUM CHLORIDE : 0.52 G) (POTASSIUM CHLORIDE : 0.3 G) (SODIUM CITRATE : 0.58 G) (GLUCOSE ANHYDROUS : 2.7 G) POWDER FOR SOLUTION,0252-150407-1171 - (METOCLOPRAMIDE : 10 MG) TABLETS, **Estimated Cost** :

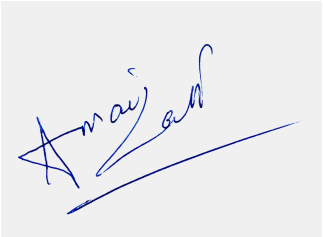
MEDICAL PRACTITIONER DECLARATION :

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 : 12-May-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 : 12-May-2025