Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	: **MA RUBIETHA SOBERANO ALPES**	**Service Date:**	**19-May-2025**
Card No	: **I020-029-119436583-03**	**Health Provider**	**:CITICARE MEDICAL CENTER LLC**
Policy Holder	: **MA RUBIETHA SOBERANO ALPES**	**Doctor's Name**	**:AISHA**
Payer Name	: **AL-BUHAIRA NATIONAL INSURANCE COMPANY**	**Co-Insurance**	:
TPA	: **E CARE - Green Network**	**Remarks**	:
Validity	: **01-02-2025** To **31-01-2026**		
Gender	: **Female**		
Date Of Birth	: **01-Jan-1984**		
Patient's Tel No	: **509412509**		

Network : Green

Direct Access SP - YES

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 : pt came with high grade fever along with mild throat and runny nose for one **Duration:** day she also has high blood pressure she is taking statins

Vitals: Temp : 38.6 Bp :163 Pulse :134 Resp :18

Clinical Findings:

Diagnosis: J02.9 - Acute pharyngitis, unspecified,R50.9 - Fever, unspecified,J30.89 - Other allergic rhinitis,E78.01 - Familial hypercholesterolemia,I10 - Essential (primary) hypertension, **Date of Onset** :19/28/2025

Requested Investigations: 85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,86140, C REACTIVE PROTEIN,80061, LIPID PANEL,2190-106618-1001, PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION,0005-149902-1021, CLOFEN - (DICLOFENAC SODIUM : 75 MG/3ML) SOLUTION FOR INJECTION,96372, THER/PROPH/DIAG INJ SC/IM,96365, THER/PROPH/DIAG IV INF INIT,9, Consultation GP **Estimated Cost** :

Prescriptions: 0097-127405-0392 - (AZITHROMYCIN : 500 MG) FILM COATED TABLETS,0195-123701-0391 - (CETIRIZINE HCL : 10 MG) FILM COATED TABLETS,0005-107001-0052 - (CAFFEINE : 65 MG) (PARACETAMOL : 500 MG) CAPLETS,0207-379203-1171 - (AMLODIPINE (AS BESYLATE) : 5MG) 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.

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

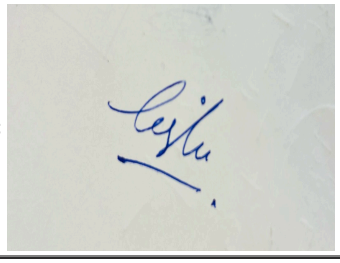
Stamp :

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

Patient 's signature{Parent if minor} :

Date : 19-May-2025

Signature :



Date : 19-May-2025