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 :24-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 : sevre pian in ear left which is severe 08 on pain scale discharge which is yellow in color , hearing is reuced and low grdae fever o/e : bp is elevated redness in ear canal serous fluid **Duration:**

Vitals: Temp : 36.8 Bp :150 Pulse :78 Resp :18

Clinical Findings:

Diagnosis: H66.007 - Ac suppr otitis media w/o spon rupt ear drum,recur, unsp ear,R52 - Pain, unspecified,R50.9 - Fever, unspecified,R03.0 - Elevated blood-pressure reading, w/o diagnosis of htn,R73.9 - Hyperglycemia, unspecified,E78.2 - Mixed hyperlipidemia, **Date of Onset** :24/49/2025

Requested Investigations: 0195-107704-0802, CEFTRIAXONE-TABUK IM,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE,0005-111805-1021, CHLOROHISTOL 10MG,96372, THER/PROPH/DIAG INJ SC/IM,2190-106618-1001, PARAFUSIV,96365, THER/PROPH/DIAG IV INF INIT,80061, LIPID PANEL,9, Consultation GP,83036, HEMOGLOBIN GLYCOSYLATED A1C,82947, GLUCOSE QUANTITATIVE BLOOD XCPT REAGENT STRIP **Estimated Cost** :

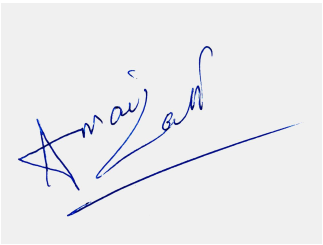
Prescriptions: 0355-171701-0241 - (BENZOCAINE : N/A) (PHENAZONE : N/A) EAR DROPS,0355-103204-1681 - (CIPROFLOXACIN : 0.3%) EYE / EAR DROPS, **Estimated Cost** :

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** : 24-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** : 24-May-2025