Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	**: ALI ISMAIL ABBOUD**	**Service Date**	**:14-Jun-2025** **Network** : Green
Card No	**: I005-029-120838063-04**	**Health Provider**	**:CITICARE MEDICAL CENTER LLC** **Direct Access SP - YES**
Policy Holder	**: ALI ISMAIL ABBOUD**	**Doctor's Name**	**:Dr.Farhan Iyas**
Payer Name	**: DUBAI INSURANCE COMPANY**	**Co-Insurance**	
TPA	**: ECARE-EBP EBP Enhanced CLASIC**	**Remarks**	**:**
Validity	**: 10-05-2025** To **09-05-2026**		
Gender	**: Male**		
Date Of Birth	**: 15-Jan-1989**		
Patient's Tel No	**: 0506011301**		

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 : p/c: sore throat body aches cold chills sometimes fever off and on **Duration :**

Vitals: Temp : 36.9 Bp :128 Pulse :86 Resp :18

Clinical Findings:

Diagnosis: J02.9 - Acute pharyngitis, unspecified,R52 - Pain, unspecified, **Date of Onset** :14/11/2025

Requested Investigations: 86140, C REACTIVE PROTEIN,85027, BLOOD COUNT COMPLETE AUTOMATED,9, Consultation GP **Estimated Cost** :

Prescriptions: 0320-148701-1171 - (LORATADINE : 10 MG) TABLETS,0005-107902-1171 - (IBUPROFEN : 400 MG) TABLETS,0397-116207-0391 - (AMOXICILLIN : 500 MG) (CLAVULANIC ACID : 125 MG) FILM COATED 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.

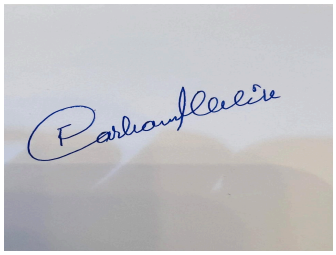
PATIENT'S DECLARATION :

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 : 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 :** 14-Jun-2025

Signature :  **Date** : 14-Jun-2025