Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	: **HASEENA MAI MOHAMMAD RIAZ**	**Service Date**	:**16-Jun-2025**
Card No	: **I011-029-119763952-01**	**Health Provider**	:**CITICARE MEDICAL CENTER LLC**
Policy Holder	: **HASEENA MAI MOHAMMAD RIAZ**	**Doctor's Name**	:**AISHA**
Payer Name	: **AL SAGR NATIONAL INSURANCE COMPANY**	**Co-Insurance**	:
TPA	: **E CARE - Blue Network**	**Remarks**	:
Validity	: **10-02-2025** To **09-02-2026**		
Gender	: **Female**		
Date Of Birth	: **01-Jan-1984**		
Patient's Tel No	: **0551778991**		

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 : pc: throat pain , ear pain and fever for the last 2 days hopc : pt. came with the complain of fever ,runny nose along with throat pain and ear blocakge o/e thraot is hyperemic ear is blocked with wax chest is clear allergy:none **Duration:**

Vitals: Temp : 37.1 Bp :100 Pulse :78 Resp :18

Clinical Findings:

Diagnosis: J02.9 - Acute pharyngitis, unspecified,R50.9 - Fever, unspecified,J30.89 - Other allergic rhinitis,R05 - Cough,H92.09 - Otalgia, unspecified ear, **Date of Onset** :16/28/2025

Requested Investigations: 85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,86140, C REACTIVE PROTEIN,9, Consultation GP **Estimated Cost** :

Prescriptions: 2593-163001-0241 - (DOCUSATE : 0.5%) EAR DROPS,0009-127405-0391 - (AZITHROMYCIN : 500 MG) FILM COATED TABLETS,0005-107001-0051 - (CAFFEINE : 65 MG) (PARACETAMOL : 500 MG) CAPLETS,0195-123701-0391 - (CETIRIZINE HCL : 10 MG) FILM COATED TABLETS, **Estimated Cost** :

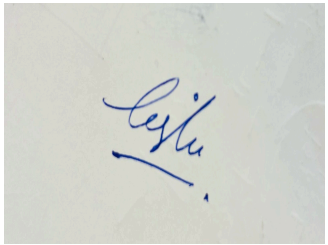
MEDICAL PRACTITIONER DECLARATION :

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.

Dr's Name : AISHA

Stamp :

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

Signature : 

Date : 16-Jun-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 : 16-Jun-2025