Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	**: ANNE ABANOUB FEKRY**
Card No	**: I009-029-122842766-01**
Policy Holder	**: ANNE ABANOUB FEKRY**
Payer Name	**: HAYAH INSURANCE COMPANY P.J.S.C**
TPA	**: E CARE - Blue Network**
Validity	**: 05-06-2025** To **04-06-2026**
Gender	**: Female**
Date Of Birth	**: 04-Jul-2023**
Patient's Tel No	**: 0556554867**

Service Date :18-Jun-2025 **Network** : Green

Health Provider **:CITICARE MEDICAL CENTER LLC** **Direct Access SP - YES**

Doctor's Name **:AISHA**

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 : productive cough hopc : pt came with the complain of low grade fever along with productive that is continous for two weeks o/e chest is congested bilaterally she is active **Duration:**

Vitals: Temp : 37.3 Bp :0 Pulse :120 Resp :24

Clinical Findings:

Diagnosis: J21.9 - Acute bronchiolitis, unspecified,R06.2 - Wheezing,J06.9 - Acute upper respiratory infection, unspecified,R50.9 - Fever, unspecified, **Date of Onset** :18/13/2025

Estimated Cost :

Requested Investigations: 9, Consultation GP

Prescriptions: 0188-135907-2441 - (BUDESONIDE : 0.25 MG/ML) SUSPENSION FOR NEBULIZATION,0005-106604-1111 - (PARACETAMOL : 120 MG/5ML) SUSPENSION,0005-114502-1171 - (AMBROXOL : 30 MG) TABLETS,0005-143604-0461 - (CEFUROXIME : 125 MG) GRANULES FOR RECONSTITUTION, **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

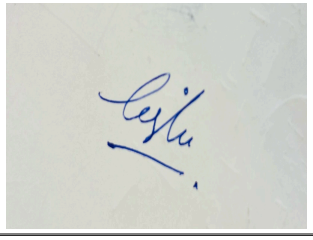
Stamp :

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

Patient 's signature{Parent if minor} :

Date : 18-Jun-2025

Signature :



Date : 18-Jun-2025