Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	: **MUHAMMAD NAVEED BAKHSH ALLAH**	**Service Date:**	**22-Jun-2025** **Network** : Green
Card No	: **I035-029-122758939-01**	**Health Provider**	**:CITICARE MEDICAL CENTER LLC** **Direct Access SP - YES**
Policy Holder	: **MUHAMMAD NAVEED BAKHSH ALLAH**	**Doctor's Name**	**:Dr.Farhan Iyas**
Payer Name	: **SALAMA – Islamic Arab Insurance Company**	**Co-Insurance**	:
TPA	: **E CARE - Blue Network**	**Remarks**	:
Validity	: **28-05-2025** To **27-05-2026**		
Gender	: **Male**		
Date Of Birth	: **10-Mar-1991**		
Patient's Tel No	: **0528990765**		

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 : chief complain: came with sore throat and dry cough started yesterday night **Duration:** 12 noon associated with fever, headache, body ache. on examination: throat is hyperemic and chest is congested allergy: no allergy with any medicine previous history: operated for fistula in 2018.

Vitals: Temp : 37.1 Bp :122 Pulse :106 Resp :18

Clinical Findings:

Diagnosis: J06.9 - Acute upper respiratory infection, unspecified,R05 - Cough,R09.81 - Nasal congestion,R06.7 - Sneezing,R51.9 - Headache, unspecified, **Date of Onset** :22/30/2025

Requested Investigations: 85004, BLOOD COUNT AUTOMATED DIFFERENTIAL WBC COUNT,86140, C REACTIVE PROTEIN,0188-135906-2441, PULMICORT,94640, AIRWAY INHALATION TREATMENT,9, Consultation GP **Estimated Cost** :

Prescriptions: 7941-044301-3852 - (SODIUM CHLORIDE : 0.9 % W/W) (N-ACETYL CYSTEINE : 1% W/W) (METHYLSULFONYLMETHANE : 1% W/W) NASAL SPRAY,0397-116207-0391 - (AMOXICILLIN : 500 MG) (CLAVULANIC ACID : 125 MG) FILM COATED TABLETS,0006-106601-0394 - (PARACETAMOL : 500 MG) FILM COATED TABLETS,0320-148701-1171 - (LORATADINE : 10 MG) TABLETS,0027-265802-1161 - (BUTAMIRATE DIHYDROGEN CITRATE : 0.15% W/V) SYRUP, **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.

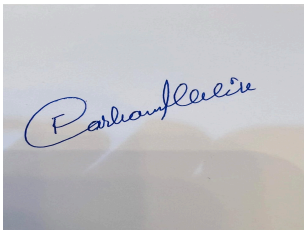
Dr's Name : Dr.Farhan Iyas

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 : 22-Jun-2025

Signature : 

Date : 22-Jun-2025