Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	**: HASSAN SHAHID**	**Service Date**	**:28-Jun-2025** **Network** : Green
Card No	**: I011-029-120623404-01**	**Health Provider**	**:CITICARE MEDICAL CENTER LLC** **Direct Access SP - YES**
Policy Holder	**: HASSAN SHAHID**	**Doctor's Name**	**:DR Amaizah**
Payer Name	**: AL SAGR NATIONAL INSURANCE COMPANY**	**Co-Insurance**	:
TPA	**: E CARE - Blue Network**	**Remarks**	:
Validity	**: 10-02-2025** To **09-02-2026**		
Gender	**: Male**		
Date Of Birth	**: 29-Oct-1983**		
Patient's Tel No	**: 0553553660**		

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 : **Duration :**

Vitals: Temp : 36.6 Bp :109 Pulse :84 Resp :18

Clinical Findings:

Diagnosis: R03.1 - Nonspecific low blood-pressure reading,R42 - Dizziness and giddiness,E86.0 - Dehydration,R00.2 - Palpitations, **Date of Onset** :28/45/2025

Requested Investigations: 0439-152905-1001, LACTATED RINGERS INJECTION USP,96360, HYDRATION IV INFUSION INIT,93000, ELECTROCARDIOGRAM COMPLETE,9, Consultation GP **Estimated Cost** :

Prescriptions: **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** : 28-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 :** 28-Jun-2025