

Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name : HASSAN SHAHID

Card No : I011-029-120623404-01

Policy Holder : HASSAN SHAHID

Payer Name : AL SAGR NATIONAL INSURANCE COMPANY

TPA : E CARE - Blue Network

Validity : 10-02-2025 To 09-02-2026

Gender : Male

Date Of Birth : 29-Oct-1983

Patient's Tel No : 0553553660

Service Date :28-Jun-2025

Health Provider :CITICARE MEDICAL CENTER LLC

Doctor's Name :DR Amaizah

Co-Insurance :

CONSULTATION	LAB/RADIOLOGY	PHYSIO	PHARMACY	IP	MATERNITY	DENTAL
10% max	NIL	NIL	NIL LIMIT	NIL	10%	NA

Remarks :

Network : Green

Direct Access SP - YES

☐ Acute

☐ Pre-existing and chronic

☐ Maternity

Chief Complaints : Duration :

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

Clinical Findings:

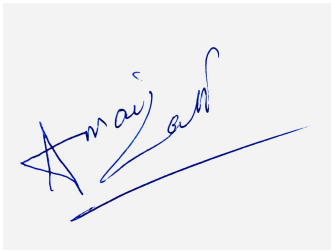
Diagnosis: R03.1 - Nonspecific low blood-pressure reading,R42 - Dizziness and giddiness,E86.0 - Dehydration,R00.2 - Palpitations, Date of Onset :28/45/2025

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

Signature :

Stamp :

Dr. Amaizah Ishtiaq
General Practitioner
DHA: 98486553-001
CITICARE MEDICAL CENTER
DUBAI - U.A.E

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 : Jun-28-2025