Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	: **ASHRAF ABDELMOKTADER HAFEZ BASHA**	**Service Date**	**:28-Jun-2025**	**Network**	: Green
Card No	: **I040-029-117339607-01**	**Health Provider**	**:CITICARE MEDICAL CENTER LLC**		**Direct Access SP - YES**
Policy Holder	: **ASHRAF ABDELMOKTADER HAFEZ BASHA**	**Doctor's Name**	**:DR Amaizah**		
Payer Name	: **UNION INSURANCE COMPANY**	**Co-Insurance**	:		
TPA	: **ECARE-EBP EBP Enhanced CLASIC**	**Remarks**	:		
Validity	: **13-01-2025** To **12-01-2026**				
Gender	: **Male**				
Date Of Birth	: **13-Dec-1974**				
Patient's Tel No	: **0508708644**				

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 : 36.8 Bp :120 Pulse :66 Resp :18

Clinical Findings:

Diagnosis: R21 - Rash and other nonspecific skin eruption,R73.9 - Hyperglycemia, unspecified,E78.5 - Hyperlipidemia, unspecified, **Date of Onset** :28/46/2025

Requested Investigations: 80061, LIPID PANEL,82947, GLUCOSE QUANTITATIVE BLOOD XCPT REAGENT STRIP,85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,9, Consultation GP **Estimated Cost** :

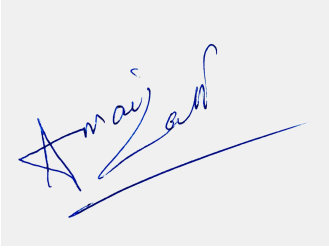
Prescriptions: 0219-187502-0151 - (BETAMETHASONE : 0.10%) (FUSIDIC ACID : 2%) CREAM, **Estimated Cost :**

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