## **Administrative**

## **MEDICAL CLAIM FORM**

## **Claim Ref:**

**Direct Access SP - YES** 

NIL 10%

MATERNITY DENTAL

NA

: Green

Patient Name

MOHAMED BELAL

: ABDELAZIZ MAHMOUD

SAAD

: 1040-029-118737797-01

**Policy** Holder

**Card No** 

**MOHAMED BELAL** : ABDELAZIZ MAHMOUD

: 02-01-2025 To 01-01-2026

SAAD

Payer

: UNION INSURANCE COMPANY Name

: E CARE - Blue Network TPA

Gender : Male

Date Of

Validity

: 12-Nov-1995

Birth Patient's

Service :07-Jul-2025 Date

:CITICARE MEDICAL CENTER LLC

:Dr.Farhan Iyas

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

Network

Remarks

Health

Provider

Doctor's

Insurance

Name

Co-

Acute	Pre-existing and chronic			☐ Maternity		
	: chief complaints: came wess on examination: hyper		e throat associated with pain, cold,	Duration:		
	p :118 Pulse :76 Resp :18	Cima iii ciii oc				
Clinical Findings:	<u> </u>					
	Acute pharyngitis, unspec	ified,R52 - Pa	in, unspecified,M54.5 - Low back pa	ain, <b>D</b> a	ate of Onset :07/	<sup>7</sup> 55/2025
	_		6372, THER/PROPH/DIAG INJ SC/IN 36140, C REACTIVE PROTEIN,9, Con		:	
1171 - (LORATADI	NE : 10 MG) TABLETS,0278	-107902-039	MG) FILM COATED TABLETS,0320-1 L - (IBUPROFEN : 400 MG) FILM CO. LAVULANIC ACID : 125 MG) FILM CO	ATED <b>Cost</b>	:	
MEDICAL PRACTI	TIONER DECLARATION :	PATIENT'S DECLARATION :				
	n the patient's medical pra owledge true and correct.	ctitioner and	that the particulars given are to		organization to recal condition & his	ovider, Insurer, lease any informatioi story for purpose of
<b>Dr's</b> : Dr.Fa <b>Name</b>	rhan Iyas	Stamp :	Dr .Frahan Ilyas Malik Physician-General Practitioner DHA-06441782-001 CITICARE MEDICAL CENTER	Patient 's signature{Parent : if minor}		07- <b>Date</b> : Jul- 202
Signature :	Parlianfluiliu	Date :	<b>DUBAI U.A.E</b> 07-Jul-2025			