Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	**: BASHAR THEYAB ESSAFADI**	**Service Date**	**:07-Jul-2025** **Network** : Green
Card No	**: I011-029-119094817-01**	**Health Provider**	**:CITICARE MEDICAL CENTER LLC** **Direct Access SP - YES**
Policy Holder	**: BASHAR THEYAB ESSAFADI**	**Doctor's Name**	**:SANDIA**
Payer Name	**: AL SAGR NATIONAL INSURANCE COMPANY**	**Co-Insurance**	:
TPA	**: E CARE - Green Network**	**Remarks**	:
Validity	**: 20-02-2025** To **19-02-2026**		
Gender	**: Male**		
Date Of Birth	**: 25-Jan-1982**		
Patient's Tel No	**: 0566899391**		

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 : pt complaints of low back pain and right shoulder pain since 3 days Pain while bending forward present Normal urination and there is no radiation of pain Pt had similar episodes 4 months back Working as maintenance manager No history of drug allergy present **Duration:**

Vitals: Temp : 36.4 Bp :108 Pulse :70 Resp :18

Clinical Findings:

Diagnosis: M54.5 - Low back pain,M62.830 - Muscle spasm of back,M62.838 - Other muscle spasm,K29.60 - Other gastritis without bleeding, **Date of Onset** :07/09/2025

Estimated Cost :

Requested Investigations: 9, Consultation GP

Prescriptions: 4884-622202-1171 - (SERRAPEPTASE : 10 MG) TABLETS,0207-533801-1451 - (ESOMEPRAZOLE (AS MAGNESIUM) : 20 MG) CAPSULES (HARD GELATIN),1703-512601-1171 - (CALCIUM CITRATE : 210.77 MG) (VITAMIN D3 : 200 IU) (MAGNESIUM HYDROXIDE : 239.9 MG) (ZINC SULPHATE : 10.978 MG) TABLETS,0278-107902-0391 - (IBUPROFEN : 400 MG) FILM COATED TABLETS,2093-596002-0432 - (DICLOFENAC DIETHYLAMINE : 23.2 MG / G) GEL,

Estimated Cost :

MEDICAL PRACTITIONER DECLARATION :

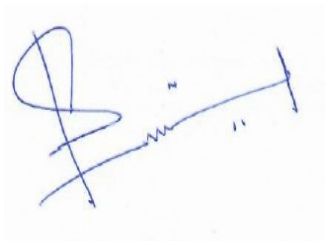
I declare that I am the patient's medical practitioner and that the particulars given are to the best of my knowledge true and correct.

Dr's Name : SANDIA

Stamp :

Dr. Sandia Bhojwani
General Practitioner
DHA No: 65900212-001
PESHAWAR MEDICAL CENTER LLC
DUBAI - U.A.E.

Signature :



Date : 07-Jul-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 : 07-Jul-2025