Administrative MEDICAL CLAIM FORM Claim Ref

Patient Name	: MOHAMED IBRAHIM KIZEKKECHELANA VEEDU EBRAHIM KUTTY	**Service Date**	:10-Jul-2025 **Network** : Green
Card No	: I005-029-121476926-01	**Health Provider**	:CITICARE MEDICAL CENTER LLC **Direct Access SP**
Policy Holder	: MOHAMED IBRAHIM KIZEKKECHELANA VEEDU EBRAHIM KUTTY	**Doctor's Name**	:AISHA
Payer Name	: DUBAI INSURANCE COMPANY	**Co-Insurance**	:
TPA	: E CARE - Blue Network	**Remarks**	:
Validity	: 02-10-2024 To 01-10-2025		
Gender	: Male		
Date Of Birth	: 30-Dec-1994		
Patient's Tel No	: 0567897077		

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

☐ **Acute** ☐ **Pre-existing and chronic** ☐ **Maternity**

Chief Complaints : PC : THROAT PAIN HOPC : PT CAME WITH THROAT PAIN AND UNABLE TO SWALLOW STARTING THIS MORNING O/E THROAT IS HYPEREMIC ALLERGIES : NONE **Duration:**

Vitals: Temp : 36.8 Bp :127 Pulse :84 Resp :18

Clinical Findings:

Diagnosis: J02.9 - Acute pharyngitis, unspecified,R07.0 - Pain in throat,R50.9 - Fever, unspecified, **Date of Onset**

Requested Investigations: 85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,86140, C REACTIVE PROTEIN,9, Consultation GP **Estimated Cost** :

Prescriptions: 0250-125820-3931 - (POVIDONE IODINE : 1%) MOUTHWASH-SOLUTION,0005-107001-0051 - (CAFFEINE : 65 MG) (PARACETAMOL : 500 MG) CAPLETS,0009-127405-0391 - (AZITHROMYCIN : 500 MG) FILM COATED TABLETS, **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.

PATIENT'S DECLARATION :

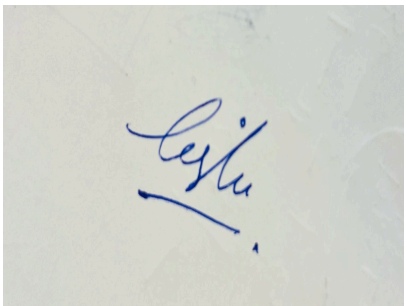
I hereby authorize any Healthca Employer or other organization regarding my medical condition determining insurance benefits.

Dr's Name : AISHA

Stamp :

Dr. Aisha Umer
Physician- General Practitioner
DHA- 40131439-002
CITICARE MEDICAL CENTER
DUBAI - U.A.E

Patient 's signature{Parent if minor} :

Signature : 

Date : 10-Jul-2025