Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	: MOHAMED IBRAHIM KIZEKKECHELANA VEEDU EBRAHIM KUTTY	**Service Date**	:11-Jul-2025
Card No	: I005-029-121476926-01	**Health Provider**	:CITICARE MEDICAL CENTER LLC
Policy Holder	: MOHAMED IBRAHIM KIZEKKECHELANA VEEDU EBRAHIM KUTTY	**Doctor's Name**	:Dr.Farhan Iyas
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		

Network : Green

Direct Access SP - YES

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 : PC : THROAT PAIN HOPC : PT CAME WITH THROAT PAIN AND UNABLE TO SWALLOW STARTING THIS MORNING O/E THROAT IS HYPEREMIC ALLERGIES : NONE investigation done: HIGH c reactive protein **Duration:**

Vitals:

Clinical Findings:

Diagnosis: R79.82 - Elevated C-reactive protein (CRP),R07.0 - Pain in throat,J02.9 - Acute pharyngitis, unspecified,R05 - Cough, **Date of Onset** :11/34/2025

Requested Investigations: 0195-107704-0801, CEFTRIAXONE-TABUK IV,0439-152905-1001, LACTATED RINGERS INJECTION USP,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE,96365, THER/PROPH/DIAG IV INF INIT,96372, THER/PROPH/DIAG INJ SC/IM **Estimated Cost** :

Prescriptions: 0278-107902-0391 - (IBUPROFEN : 400 MG) FILM COATED TABLETS,0027-265802-1161 - (BUTAMIRATE DIHYDROGEN CITRATE : 0.15% W/V) SYRUP, **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.

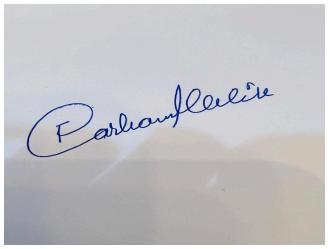
PATIENT'S DECLARATION :

I hereby authorize any Healthcare provider, Insurer, Employer or other organization to release any information regarding my medical condition & history for purpose of determining insurance benefits.

Dr's Name : Dr.Farhan Iyas **Stamp :**

Dr .Frahan Ilyas Malik
Physician-General Practitioner
DHA-06441782-001
CITICARE MEDICAL CENTER
DUBAI U.A.E

Patient 's signature{Parent if minor} : **Date** : 11-Jul-2025

Signature :  **Date** : 11-Jul-2025