Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name : MHD SALEEM KHALED
Card No : I011-029-121441249-01
Policy Holder : MHD SALEEM KHALED
Payer Name : AL SAGR NATIONAL INSURANCE COMPANY
TPA : ECARE-EBP EBP Enhanced CLASIC
Validity : 16-06-2025 To 15-06-2026
Gender : Male
Date Of Birth : 07-Jul-2000
Patient's Tel No : 0523994370

Service Date :16-Jul-2025 **Network** : Green
Health Provider :CITICARE MEDICAL CENTER LLC **Direct Access SP - YES**
Doctor's Name :AISHA
Co-Insurance :

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

Remarks :

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

Chief Complaints : pc : migraine and left sided tooth pain hopc : pt came with severe left sided headache along with left sided facial pain stared this morning o/e he looked irritaed and pain scale is 7/10 non allergic to any medication no past medical history other than migraine **Duration:**

Vitals: Temp : 36.8 Bp :120 Pulse :70 Resp :18

Clinical Findings:

Diagnosis: G43.719 - Chronic migraine w/o aura, intractable, w/o stat migr,R50.9 - Fever, unspecified,R52 - Pain, unspecified,P74.1 - Dehydration of newborn, **Date of Onset** :16/35/2025

Requested Investigations: 85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,86140, C REACTIVE PROTEIN,2190-106618-1001, PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION,96365, THER/PROPH/DIAG IV INF INIT,0102-100104-1001, SODIUM CHLORIDE & DEXTROSE B.P.,96374, THER/PROPH/DIAG INJ IV PUSH,0005-149902-1021, CLOFEN -(DICLOFENAC SODIUM : 75 MG/3ML) SOLUTION FOR INJECTION,96372, THER/PROPH/DIAG INJ SC/IM,9, Consultation GP **Estimated Cost** :

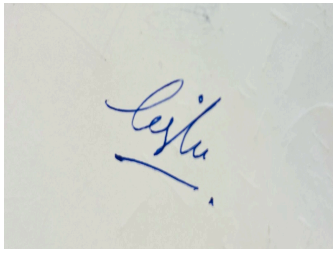
Prescriptions: 0278-107902-0391 - (IBUPROFEN : 400 MG) FILM COATED TABLETS,0186-258002-0391 - (ELETRIPTAN : 40 MG) FILM COATED TABLETS, **Estimated Cost** :

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.

Dr's Name : AISHA **Stamp :**

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

Signature :  **Date** : 16-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 :** 16-Jul-2025