

Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name : MHD SALEEM KHALED
 Card No : I011-029-121441249-01
 Policy Holder : MHD SALEEM KHALED

Service Date :16-Jul-2025

Network

: Green

Health Provider :CITICARE MEDICAL CENTER LLC

Direct Access SP - YES

Doctor's Name :AISHA

Payer Name : AL SAGR NATIONAL INSURANCE COMPANY

Co-Insurance

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

TPA : ECARE-EBP EBP Enhanced CLASIC

Remarks :

Validity : 16-06-2025 To 15-06-2026

Gender : Male

Date Of Birth : 07-Jul-2000

Patient's Tel No : 0523994370

☐ 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 started 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

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** :16/37/2025

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,0439-152905-1001, LACTATED RINGERS INJECTION USP,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 :

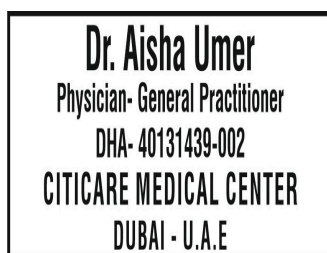
I declare that I am the patient's medical practitioner and that the particulars given are to the best of my knowledge true and correct.

PATIENT'S DECLARATION :

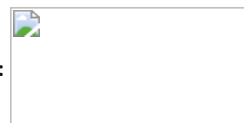
I hereby authorize any Healthcare provider, Insurer, Employer or other organization to release any information regarding my medical condition & history for purpose of determining insurance benefits.

Dr's Name : AISHA

Stamp :



Patient 's signature{Parent : if minor}



16-
Date : Jul-
2025

Signature :

Date : 16-Jul-2025