Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	**: MHD SALEEM KHALED**	**Service Date**	**:16-Jul-2025** **Network** : Green
Card No	**: I011-029-121441249-01**	**Health Provider**	**:CITICARE MEDICAL CENTER LLC** **Direct Access SP - YES**
Policy Holder	**: MHD SALEEM KHALED**	**Doctor's Name**	**:AISHA**
Payer Name	**: AL SAGR NATIONAL INSURANCE COMPANY**	**Co-Insurance**	:
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**		

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 : 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,E86.0 - Dehydration,R53.83 - Other fatigue, **Date of Onset** :16/56/2025

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,96360, HYDRATION IV INFUSION INIT **Estimated Cost** :

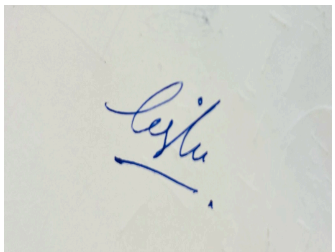
Prescriptions: 0278-107902-0391 - (IBUPROFEN : 400 MG) FILM COATED TABLETS,0186-258002-0391 - (ELETRIPTAN : 40 MG) FILM COATED TABLETS, **Estimated Cost** :

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