Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	**: HAZAR ADEEB SHAHEEN**	**Service Date**	**:17-Jul-2025** **Network** : Green
Card No	**: I011-029-120774102-01**	**Health Provider**	**:CITICARE MEDICAL CENTER LLC** **Direct Access SP - YES**
Policy Holder	**: HAZAR ADEEB SHAHEEN**	**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	**: Female**		
Date Of Birth	**: 13-Oct-1999**		
Patient's Tel No	**: 0505683368**		

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 : low back pain and burning micturation hopc : pt came with low back pain along with burning micturation for the last one week o/e she looked dehydrated and blood pressure is also low no allergies no past medical history **Duration:**

Vitals: Temp : 37 Bp :115 Pulse :81 Resp :0

Clinical Findings:

Diagnosis: N39.0 - Urinary tract infection, site not specified,R50.9 - Fever, unspecified,R30.0 - Dysuria,E86.0 - Dehydration, **Date of Onset** :17/33/2025

Requested Investigations: 85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,86140, C REACTIVE PROTEIN,81003, URNLS DIP STICK TABLET RGNT AUTO WO MICROSCOPY,2190-106618-1001, PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION,96374, THER/PROPH/DIAG INJ IV PUSH,0005-136504-1021, SCOPINAL-(HYOSCINE : 20 MG/ML) SOLUTION FOR INJECTION,96372, THER/PROPH/DIAG INJ SC/IM,0439-152905-1001, LACTATED RINGERS INJECTION USP,96360, HYDRATION IV INFUSION INIT,9, Consultation GP **Estimated Cost** :

Prescriptions: 0135-223402-1171 - (NAPROXEN : 250 MG) TABLETS,3114-482003-0391 - (CIPROFLOXACIN (AS HYDROCHLORIDE) : 500 MG) FILM COATED TABLETS,6619-548302-0251 - (SODIUM BICARBONATE : 1.76G) (SODIUM CITRATE ANHYDROUS : 0.63G) (TARTARIC ACID : 0.89G) (CITRIC ACID ANHYDROUS : 0.715 G) EFFERVESCENT GRANULES, **Estimated Cost** :

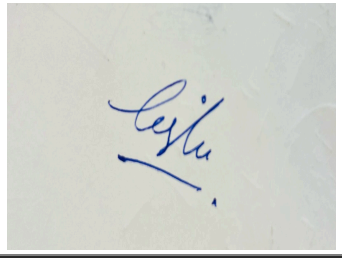
MEDICAL PRACTITIONER DECLARATION :

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 : 17-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 : 17-Jul-2025