Administrative MEDICAL CLAIM FORM Claim Ref

Patient Name	: **AZHAR MEHMOOD KHAN MUHAMMAD SAFDAR KHAN**	**Service Date**	**:05-Aug-2025**	**Network**	: Green
Card No	: **I011-029-118340965-01**	**Health Provider**	**:CITICARE MEDICAL CENTER LLC**		**Direct Access SP**
Policy Holder	: **AZHAR MEHMOOD KHAN MUHAMMAD SAFDAR KHAN**	**Doctor's Name**	**:KEERTHANA**		
Payer Name	: **AL SAGR NATIONAL INSURANCE COMPANY**	**Co-Insurance**	:		
TPA	: **E CARE - Blue Network**				
Validity	: **20-02-2025** To **20-02-2026**	**Remarks**	:		
Gender	: **Male**				
Date Of Birth	: **21-Dec-1987**				
Patient's Tel No	: **0563776456**				

CONSULTATION	LAB/RADIOLOGY	PHYSIO	PHARMACY	IP	MATEF
10% max	NIL	NIL	NIL LIMIT	NIL	10%

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

Chief Complaints : PC left sided headache HOPC pt presented with complaints of left sided pulsating headache,pain back of neck since yesterday Not associated with fever\nausea\vomiting He had proper sleep O\e conscious oriented BP IS high 160\100 mmHg No history of drug allergy K\C\O\ T2DM on insulin **Duration:**

Vitals: Temp : 36.6 Bp :160 Pulse :88 Resp :18

Clinical Findings:

Diagnosis: R51.9 - Headache, unspecified, **Date of Onset** : 05/36/20

Requested Investigations: 0005-149902-1021, CLOFEN -(DICLOFENAC SODIUM : 75 MG/3ML) SOLUTION FOR INJECTION,9, Consultation GP,96372, THER/PROPH/DIAG INJ SC/IM **Estimated Cost** :

Prescriptions: 0240-223401-1171 - (NAPROXEN : 500 MG) 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 Healthca Employer or other organization regarding my medical condition determining insurance benefits.

Dr's Name : KEERTHANA **Stamp :**

د. كيرثانا راني باديبورايل ثارا
Dr. Keerthana Rani Padippurayil Thara
General Practitioner
License No.: 37864046-001
مـركـز سيتيكير الطبي ذ م م
CITICARE MEDICAL CENTER LLC

Patient 's signature{Parent if minor} :

Signature : **Date** : 05-Aug-2025