Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	: **AMAL MOHAMMED MOHAMMED RAFI**	**Service Date**	:**09-Aug-2025** **Network** : Green
Card No	: **I005-029-121485466-01**	**Health Provider**	:**CITICARE MEDICAL CENTER LLC** **Direct Access SP - YES**
Policy Holder	: **AMAL MOHAMMED MOHAMMED RAFI**	**Doctor's Name**	:**Dr.Farhan Iyas**
Payer Name	: **DUBAI INSURANCE COMPANY**	**Co-Insurance**	:
TPA	: **E CARE - Blue Network**	**Remarks**	:
Validity	: **02-10-2024** To **01-10-2025**		
Gender	: **Male**		
Date Of Birth	: **09-Mar-2000**		
Patient's Tel No	: **0585395467**		

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 : chief complain: came with sore throat started yesterday 08/08/25 associated with dry cough sometimes, nasal congestion, headache, body pain and weakness on examination: hyperemia and chest is normal pain scale 5 allergy: cobadex(vitamin b12 + vitamin C) **Duration:**

Vitals: Temp : 36.6 Bp :100 Pulse :82 Resp :18

Clinical Findings:

Diagnosis: J02.9 - Acute pharyngitis, unspecified,R51.9 - Headache, unspecified,R53.1 - Weakness,R09.81 - Nasal congestion,R06.2 - Wheezing, **Date of Onset** :09/07/2025

Requested Investigations: 0188-135906-2441, PULMICORT,85004, BLOOD COUNT AUTOMATED DIFFERENTIAL WBC COUNT,86140, C REACTIVE PROTEIN,94640, AIRWAY INHALATION TREATMENT,9, Consultation GP **Estimated Cost** :

Prescriptions: 0320-148701-1171 - (LORATADINE : 10 MG) TABLETS,0006-106601-0393 - (PARACETAMOL : 500 MG) FILM COATED TABLETS,0397-116207-0391 - (AMOXICILLIN : 500 MG) (CLAVULANIC ACID : 125 MG) FILM COATED TABLETS, **Estimated Cost** :

MEDICAL PRACTITIONER DECLARATION :

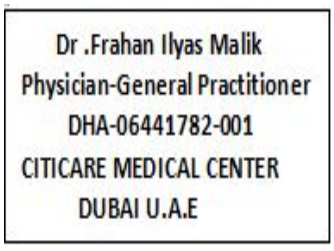
I declare that I am the patient's medical practitioner and that the particulars given are to the best of my knowledge true and correct.

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 : Dr.Farhan Iyas

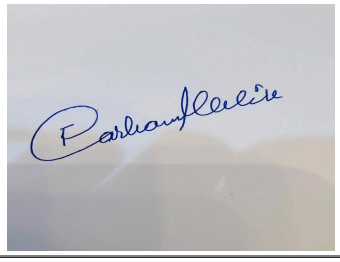
Stamp :



Patient 's signature{Parent if minor} :

Date : 09-Aug-2025

Signature :



Date : 09-Aug-2025