Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	: **ABDELRAHMAN DAOUD ABDELRAHMAN ELSHIKH**	**Service Date**	**:10-Aug-2025**
Card No	: **I011-029-119805839-01**	**Health Provider**	**:CITICARE MEDICAL CENTER LLC**
Policy Holder	: **ABDELRAHMAN DAOUD ABDELRAHMAN ELSHIKH**	**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	: **21-May-1998**		
Patient's Tel No	: **0558016424**		

Network : Green

Direct Access SP - YES

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 : **Duration :**

Vitals:

Clinical Findings:

Diagnosis: S61.200A - Unsp open wound of r idx fngr w/o damage to nail, init, **Date of Onset** :10/53/2025

Requested Investigations: 51.02, Non-surgical cleansing with surgical dressing between 16 sq inches / 100 sq centimeters and 48 sq inches / 300 sq centimeters,9.01, Follow Up Consultation GP **Estimated Cost** :

Prescriptions: **Estimated Cost** :

MEDICAL PRACTITIONER DECLARATION :

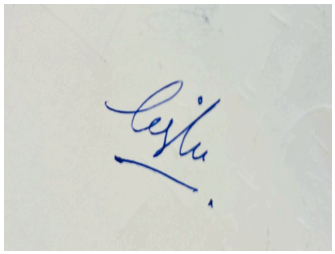
I declare that I am the patient's medical practitioner and that the particulars given are to the best of my knowledge true and correct.

Dr's Name : AISHA

Stamp :

Dr. Aisha Umer
Physician- General Practitioner
DHA- 40131439-002
CITICARE MEDICAL CENTER
DUBAI - U.A.E

Signature :



Date : 10-Aug-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 : 10-Aug-2025