Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	: **CATHYRENE ESTUYA APURADA**	**Service Date**	:**10-Aug-2025** **Network** : Green
Card No	: **I011-029-121962882-01**	**Health Provider**	:**CITICARE MEDICAL CENTER LLC** **Direct Access SP - YES**
Policy Holder	: **CATHYRENE ESTUYA APURADA**	**Doctor's Name**	:**DR Amaizah**
Payer Name	: **AL SAGR NATIONAL INSURANCE COMPANY**	**Co-Insurance**	:
TPA	: **E CARE - Blue Network**	**Remarks**	:
Validity	: **13-03-2025** To **12-03-2026**		
Gender	: **Female**		
Date Of Birth	: **10-Nov-1987**		
Patient's Tel No	: **0545648080**		

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 : severe pain in epigastric region , and nuasea , vomitting , low garde fever started 09/08/25 loose stool 07 episodes today , o/e : look dehydrated and pale tender epigastric **Duration:**

Vitals: Temp : 36.2 Bp :120 Pulse :80 Resp :18

Clinical Findings:

Diagnosis: R19.7 - Diarrhea, unspecified,K29.00 - Acute gastritis without bleeding,E86.0 - Dehydration,R10.816 - Epigastric abdominal tenderness,R11.2 - Nausea with vomiting, unspecified, **Date of Onset** :10/35/2025

Requested Investigations: 0439-152905-1001, LACTATED RINGERS INJECTION USP,0005-136504-1021, SCOPINAL,0005-150403-1021, PREMOSAN -(METOCLOPRAMIDE : 10 MG/2ML) SOLUTION FOR INJECTION,96372, THER/PROPH/DIAG INJ SC/IM,INJ060, INJ-METRONIDAZOLE 500 MG/100ML - IV,96360, HYDRATION IV INFUSION INIT,9, Consultation GP **Estimated Cost** :

Prescriptions: 0005-136501-0392 - (HYOSCINE : 10 MG) FILM COATED TABLETS,0415-200001-1452 - (LOPERAMIDE : 2 MG) CAPSULES (HARD GELATIN),6619-230505-0831 - (SODIUM CHLORIDE : 2.6 G) (POTASSIUM CHLORIDE : 1.5 G) (SODIUM CITRATE : 2.9 G) (DEXTROSE ANHYDROUS : 13.5 G) POWDER FOR SOLUTION, **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 Amaizah **Stamp :**

Dr. Amaizah Ishtiaq
General Practitioner
DHA: 98486553-001
CITICARE MEDICAL CENTER
DUBAI - U.A.E

Patient 's signature{Parent if minor} : **Date :** 10-Aug-2025

Signature : **Date** : 10-Aug-2025