Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	**: MOHAMED MAHMOUD ELSAID MOHAMED GHANEM**
Card No	**: I011-029-122888214-01**
Policy Holder	**: MOHAMED MAHMOUD ELSAID MOHAMED GHANEM**
Payer Name	**: AL SAGR NATIONAL INSURANCE COMPANY**
TPA	**: E CARE - Blue Network**
Validity	**: 16-06-2025** To **15-06-2026**
Gender	**: Male**
Date Of Birth	**: 31-Jan-1998**
Patient's Tel No	**: 0506758990**

Service Date **:14-Aug-2025** **Network** : Green

Health Provider **:CITICARE MEDICAL CENTER LLC** **Direct Access SP - YES**

Doctor's Name **:SANDIA**

Co-Insurance :

CONSULTATION	LAB/RADIOLOGY	PHYSIO	PHARMACY	IP	MATERNITY	DENTAL
10% max	NIL	NIL	NIL LIMIT	NIL	10%	NA

Remarks :

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

Chief Complaints : pt has swelling filled fluid started 2 days it was painful before not painful now but sometimes pain, no difficulty on walking started on its own no history of injury, its blister not painful on touch **Duration:**

Vitals: Temp : 36.5 Bp :110 Pulse :78 Resp :18

Clinical Findings:

Diagnosis: R21 - Rash and other nonspecific skin eruption,R51.9 - Headache, unspecified,R50.9 - Fever, unspecified, **Date of Onset** :14/53/2025

Requested Investigations: 9, Consultation GP,10061, INCISION&DRAINAGE ABSCESS COMPLICATED/MULTIPLE **Estimated Cost** :

Prescriptions: 0195-187502-0151 - (BETAMETHASONE : 0.10%) (FUSIDIC ACID : 2%) CREAM,2689-107001-0391 - (PARACETAMOL : 500 MG) (CAFFEINE : 65 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.

Dr's Name : SANDIA **Stamp :**

Dr. Sandia Bhojwani
General Practitioner
DHA No: 65900212-001
PESHAWAR MEDICAL CENTER LLC
DUBAI - U.A.E.

Signature : **Date** : 14-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 :** 14-Aug-2025