Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	: **AHMAD JAMEEL MUHAMMMAD JAMEEL**	**Service Date**	:**14-Aug-2025** **Network** : Green
Card No	: **I040-029-119282953-01**	**Health Provider**	:**CITICARE MEDICAL CENTER LLC** **Direct Access SP - YES**
Policy Holder	: **AHMAD JAMEEL MUHAMMMAD JAMEEL**	**Doctor's Name**	:**DR Amaizah**
Payer Name	: **UNION INSURANCE COMPANY**	**Co-Insurance**	:
TPA	: **E CARE - Blue Network**	**Remarks**	:
Validity	: **23-06-2025** To **22-06-2026**		
Gender	: **Male**		
Date Of Birth	: **29-Nov-2001**		
Patient's Tel No	: **0521940156**		

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 : itching and lesions lower back and buttock cauing severe discomfort and **Duration:**
pain associated with , low garde fever works as delivery agent , remain seated most of time o/e
: pustular lesions on sacral region and buttock and serosanginus discharge

Vitals: Temp : 37 Bp :110 Pulse :100 Resp :18

Clinical Findings:

Diagnosis: R21 - Rash and other nonspecific skin eruption,L03.317 - Cellulitis of buttock,R50.9 - Fever, unspecified,M54.5 - Low back pain, **Date of Onset** :14/10/2025

Requested Investigations: 0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE,85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,86140, C REACTIVE PROTEIN,96372, THER/PROPH/DIAG INJ SC/IM,0005-149902-1021, CLOFEN ,9, Consultation GP **Estimated Cost** :

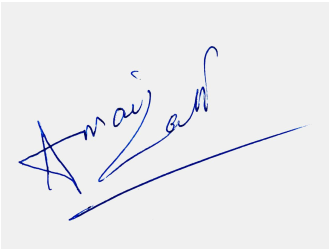
Prescriptions: 0397-116206-1171 - (CLAVULANIC ACID : 125 MG) (AMOXICILLIN : 875 MG) TABLETS, **Estimated Cost** :

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.

Dr's Name : DR Amaizah **Stamp :**

Dr. Amaizah Ishtiaq
General Practitioner
DHA: 98486553-001
CITICARE MEDICAL CENTER
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