Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	: **MUHAMMAD WAQAR IQBAL MUHAMMAD IQBAL**	**Service Date**	**:17-Aug-2025**	**Network**	: Green
Card No	: **I040-029-117640207-01**	**Health Provider**	**:CITICARE MEDICAL CENTER LLC**	**Direct Access SP - YES**	
Policy Holder	: **MUHAMMAD WAQAR IQBAL MUHAMMAD IQBAL**	**Doctor's Name**	**:DR Amaizah**		
Payer Name	: **UNION INSURANCE COMPANY**	**Co-Insurance**	:		
TPA	: **E CARE - Green Network**	**Remarks**	:		
Validity	: **01-10-2024** To **30-09-2025**				
Gender	: **Male**				
Date Of Birth	: **04-Apr-1994**				
Patient's Tel No	: **0501381506**				

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 ; sore throat , bodypain sevre 08 on pain score sneezing ,high grade fever **Duration:** started 14/08/25 loss of appetite , nausea and vomitting cough which is with sputum o/e : hypermic pharynx tonsils are swollen chest is congested

Vitals: Temp : 37.8 Bp :120 Pulse :97 Resp :18

Clinical Findings:

Diagnosis: J06.9 - Acute upper respiratory infection, unspecified,R05 - Cough,J30.9 - Allergic rhinitis, unspecified,R50.9 - Fever, unspecified, **Date of Onset** :17/06/2025

Requested Investigations: 2190-106618-1001, PARAFUSIV,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE,0005-111805-1021, CHLOROHISTOL 10MG,0005-149902-1021, CLOFEN ,96365, THER/PROPH/DIAG IV INF INIT,0439-152905-1001, LACTATED RINGERS INJECTION USP,87075, CULTURE BACTERIAL ANY SOURCE ANAEROBIC ISO&ID,9, Consultation GP,0195-107704-0801, CEFTRIAXONE-TABUK IV,96372, THER/PROPH/DIAG INJ SC/IM,96374, THER/PROPH/DIAG INJ IV PUSH,96360, HYDRATION IV INFUSION INIT **Estimated Cost** :

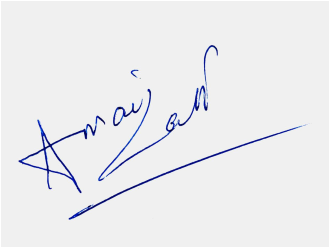
Prescriptions: **Estimated Cost** :

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 : DR Amaizah **Stamp :**

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

Signature :  **Date** : 17-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 :** 17-Aug-2025