Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	: **NAZIA HASSAN IFFIKHAR HASSAN**	**Service Date**	:**20-Aug-2025** **Network** : Green
Card No	: **I011-029-120988468-01**	**Health Provider**	:**CITICARE MEDICAL CENTER LLC** **Direct Access SP - YES**
Policy Holder	: **NAZIA HASSAN IFFIKHAR HASSAN**	**Doctor's Name**	:**KEERTHANA**
Payer Name	: **AL SAGR NATIONAL INSURANCE COMPANY**	**Co-Insurance**	:
TPA	: **E CARE - Blue Network**	**Remarks**	:
Validity	: **10-02-2025** To **09-02-2026**		
Gender	: **Female**		
Date Of Birth	: **24-Dec-1980**		
Patient's Tel No	: **0547352576**		

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 pain left knee HOPC pt complaints of pain left knee following slip and fall on monday O\E tenderness present mild edema + No history of drug allergy Nil comorbs **Duration:**

Vitals: Temp : 36.6 Bp :110 Pulse :82 Resp :18

Clinical Findings:

Diagnosis: M25.562 - Pain in left knee,R60.0 - Localized edema, **Date of Onset** : 20/10/2025

Estimated Cost :

Requested Investigations: 9, Consultation GP

Estimated Cost :

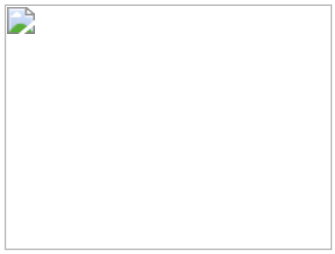
Prescriptions: 0207-142201-0391 - (DICLOFENAC POTASSIUM : 50 MG) FILM COATED TABLETS,

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 : KEERTHANA **Stamp :**

د. كيرثانا راني بادييورايل ثارا
Dr. Keerthana Rani Padippurayil Thara
General Practitioner
License No.: 37864046-001
مـركـز سيتيكير الطبي ذ م م
CITICARE MEDICAL CENTER LLC

Signature :  **Date** : 20-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 :** 20-Aug-2025