Administrative **MEDICAL CLAIM FORM** **Claim Ref:**

Patient Name	: **LUAI SHELEEK MOHAMMED SHELEEK MASHOOD**	**Service Date**	**:24-Aug-2025**	**Network**	: Green
Card No	: **I005-029-122780984-01**	**Health Provider**	**:CITICARE MEDICAL CENTER LLC**	**Direct Access SP - YES**	
Policy Holder	: **LUAI SHELEEK MOHAMMED SHELEEK MASHOOD**	**Doctor's Name**	**:DR Amaizah**		
Payer Name	: **DUBAI INSURANCE COMPANY**	**Co-Insurance**	:		
TPA	: **E CARE - Blue Network**				
Validity	: **02-10-2024** To **01-10-2025**	**Remarks**	:		
Gender	: **Male**				
Date Of Birth	: **08-Jan-2025**				
Patient's Tel No	: **0585769693**				

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 : high grade fever and runny nose , nasal blockage , and cough with sputum hx of vomitting started 23/08/25 o/e : look lethargic temp 37.4 c chest wheeze **Duration:**

Vitals: Temp : 37.7 Bp :0 Pulse :102 Resp :22

Clinical Findings:

Diagnosis: **Date of Onset** : 25/04/2025

Requested Investigations: 85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,86140, C REACTIVE PROTEIN,94640, AIRWAY INHALATION TREATMENT,9, Consultation GP **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.

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 :** 25-Aug-2025

Signature : **Date** : 25-Aug-2025