Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	: **KAMRAN SAFDAR SAFDAR Ali**	**Service Date**	:**11-Aug-2024**	**Network**	: Green
Card No	: **I011-029-120166741-02**	**Health Provider**	:**CITICARE MEDICAL CENTER LLC**	**Direct Access SP - YES**	
Policy Holder	: **KAMRAN SAFDAR SAFDAR Ali**	**Doctor's Name**	:**Humaira**		
Payer Name	: **AL SAGR NATIONAL INSURANCE COMPANY**	**Co-Insurance**	:		
TPA	: **E CARE - Green Network**	**Remarks**	:		
Validity	: **19-06-2024** To **18-06-2025**				
Gender	: **Male**				
Date Of Birth	: **04-Jan-1991**				
Patient's Tel No	: **0551376756**				

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 : co diarrhea 4 episode 7th august 2024 oe chest is clear no addede sounds restless dehydrated history of foood that was not fresh **Duration:**

Vitals: Temp : 36 Bp :136 Pulse :64 Resp :18

Clinical Findings:

Diagnosis: R19.7 - Diarrhea, unspecified,E86.0 - Dehydration,R50.9 - Fever, unspecified, **Date of Onset** :11/55/2024

Requested Investigations: 85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,81001, URNLS DIP STICK/TABLET REAGENT AUTO MICROSCOPY,87045, CUL BACT STOOL AEROBIC ISOL SALMONELLA&SHIGELLA,86140, C REACTIVE PROTEIN,0195-107704-0801, CEFTRIAXONE-TABUK IV,0102-152902-1001, LACTATED RINGERS INJECTION USP,96365, THER/PROPH/DIAG IV INF INIT,96360, HYDRATION IV INFUSION INIT,9, Consultation GP,0005-149902-1021, CLOFEN -(DICLOFENAC SODIUM : 75 MG/3ML) SOLUTION FOR INJECTION,96372, THER/PROPH/DIAG INJ SC/IM **Estimated Cost :**

Prescriptions: 1795-502202-1451 - (SPORE OF BACILLUS CLAUSI : 2 BILLION) CAPSULES (HARD GELATIN),0102-230603-0831 - (ORAL REHYDRATION SALTS (O.R.S.) : N/A) POWDER FOR SOLUTION,0195-116604-0391 - (METRONIDAZOLE : 500 MG) FILM COATED TABLETS,0005-107001-0051 - (CAFFEINE : 65 MG) (PARACETAMOL : 500 MG) CAPLETS,0054-103201-0391 - (CIPROFLOXACIN : 500 MG) FILM COATED TABLETS, **Estimated Cost :**

MEDICAL PRACTITIONER DECLARATION : **PATIENT'S 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.

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 : Humaira

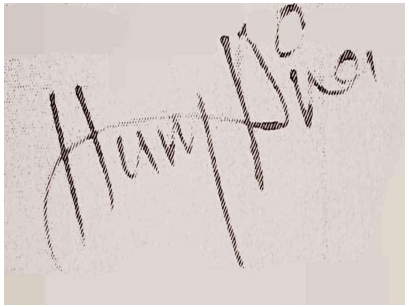
Stamp :

Dr. Humaira Mumtaz
General Practitioner
DHA No: 54155530-002
CITICARE MEDICAL CENTER LLC
DUBAI - U.A.E.

Patient 's signature{Parent : if minor}

Date : 11-Aug-2024

Signature :



Date : 11-Aug-2024