Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	: **ZEESHAN AHMAD AZIZ AHMAD**	**Service Date**	:**04-Sep-2024** **Network** : Green
Card No	: **I011-029-119743227-02**	**Health Provider**	:**CITICARE MEDICAL CENTER LLC** **Direct Access SP - YES**
Policy Holder	: **ZEESHAN AHMAD AZIZ AHMAD**	**Doctor's Name**	:**AHSAN HUSSAIN**
Payer Name	: **AL SAGR NATIONAL INSURANCE COMPANY**	**Co-Insurance**	:
TPA	: **E CARE - Blue Network**	**Remarks**	:
Validity	: **19-06-2024** To **18-06-2025**		
Gender	: **Male**		
Date Of Birth	: **07-Jan-1990**		
Patient's Tel No	: **0561427224**		

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 : cough productive of thick clear sputum Also upper abdominal pain that is burning and radiates to the back. Fever **Duration:**

Vitals:

Clinical Findings:

Diagnosis: J20.9 - Acute bronchitis, unspecified,J22 - Unspecified acute lower respiratory infection,K29.00 - Acute gastritis without bleeding,R50.9 - Fever, unspecified, **Date of Onset** :04/49/2024

Requested Investigations: 0195-107704-0801, CEFTRIAXONE-TABUK IV,9.01, Follow Up Consultation GP,96365, THER/PROPH/DIAG IV INF 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 : AHSAN HUSSAIN **Stamp :**

Dr. Ahsan Hussain
General Practitioner
DHA No: 87543658-001
CITICARE MEDICAL CENTER LLC
DUBAI - U.A.E.

Signature : **Date** : 04-Sep-2024

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** : 04-Sep-2024