

Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name : ZEESHAN AHMAD AZIZ AHMAD

Card No : I011-029-119743227-02

Policy Holder : ZEESHAN AHMAD AZIZ AHMAD

Payer Name : AL SAGR NATIONAL INSURANCE COMPANY

TPA : E CARE - Blue Network

Validity : 19-06-2024 To 18-06-2025

Gender : Male

Date Of Birth : 07-Jan-1990

Patient's Tel No : 0561427224

Service Date :04-Sep-2024

Health Provider :CITICARE MEDICAL CENTER LLC

Doctor's Name :AHSAN HUSSAIN

Co-Insurance

Remarks :

Network : Green

Direct Access SP - YES

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:

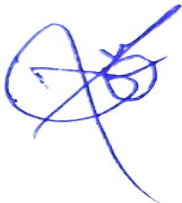
MEDICAL PRACTITIONER DECLARATION :
I declare that I am the patient's medical practitioner and that the particulars given are to the best of my knowledge true and correct.

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}



04-Sep-2024