Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	: MUHAMMAD BAHIR	**Service Date**	:01-Jul-2024
Card No	: I022-029-114042580-01	**Health Provider**	:CITICARE MEDICAL CENTER LLC
Policy Holder	: MUHAMMAD BAHIR	**Doctor's Name**	:Enomen Goodluck
Payer Name	: TAKAFUL EMARAT		
TPA	: E CARE - Blue Network		
Validity	: 30-08-2023 To 29-08-2024		
Gender	: Male		
Date Of Birth	: 16-Jun-1990		
Patient's Tel No	: 765697144		

Network : Green

Direct Access SP - YES

Co-Insurance :

CONSULTATION	LAB/RADIOLOGY	PHYSIO	PHARMACY	IP	MATERNITY	DENTAL
10% max	NIL	NIL	NIL LIMIT	NIL	10%	NA

Remarks :

☐ **Acute** ☐ **Pre-existing and chronic** ☐ **Maternity**

Chief Complaints : C/o: Pain in throat, especially upon swallowing, slight cough, fever and generalized body pains. and weakness. **Duration:**

Vitals: Temp : 36.9 Bp :138 Pulse :70 Resp :18

Clinical Findings:

Diagnosis: J06.9 - Acute upper respiratory infection, unspecified,R50.9 - Fever, unspecified,R53.1 - Weakness, **Date of Onset :**01/38/2024

Estimated Cost :

Requested Investigations: 9, Consultation GP

Prescriptions: 0027-265802-1161 - (BUTAMIRATE DIHYDROGEN CITRATE : 0.15% W/V) SYRUP,0097-127405-0392 - (AZITHROMYCIN : 500 MG) FILM COATED TABLETS,5363-863401-1171 - (PARACETAMOL : 400 MG) (PSEUDOEPHEDRINE HCL : 30 MG) (CAFFEINE : 32 MG) (CHLORPHENIRAMINE MALEATE : 3 MG) TABLETS,0070-148701-1171 - (LORATADINE : 10 MG) TABLETS,2027-560101-0392 - (IBUPROFEN : 150 MG) (PARACETAMOL : 500 MG) FILM COATED TABLETS, **Estimated Cost :**

MEDICAL PRACTITIONER DECLARATION :

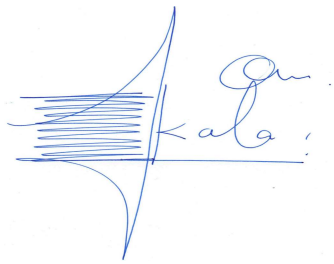
I declare that I am the patient's medical practitioner and that the particulars given are to the best of my knowledge true and correct.

Dr's Name : Enomen Goodluck

Stamp :

Dr. Enomen Goodluck Ekata
General Practitioner
DHA No: 28040827-001
CITICARE MEDICAL CENTER LLC
DUBAI - U.A.E.

Signature :



Date : 01-Jul-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 : 01-Jul-2024