Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	: **ISLAM HAFSI**	**Service Date**	:**24-Jul-2024**
Card No	: **I022-029-120338346-01**	**Health Provider**	:**CITICARE MEDICAL CENTER LLC**
Policy Holder	: **ISLAM HAFSI**	**Doctor's Name**	:**Humaira**
Payer Name	: **TAKAFUL EMARAT**		
TPA	: **E CARE - Blue Network**		
Validity	: **17-01-2024** To **16-01-2025**		
Gender	: **Female**	**Remarks**	:
Date Of Birth	: **07-Oct-1988**		
Patient's Tel No	: **0521706901**		

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

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

Chief Complaints : co muscle pain constipation on the back pain in the small joints 18th july 2024 oe muscular strain chest is clear no added sounds restless **Duration:**

Vitals: Temp : 36.6 Bp :90 Pulse :62 Resp :18

Clinical Findings:

Diagnosis: M62.830 - Muscle spasm of back,M19.90 - Unspecified osteoarthritis, unspecified site,R22.40 - Localized swelling, mass and lump, unspecified lower limb,K56.41 - Fecal impaction, **Date of Onset** :24/37/2024

Requested Investigations: 86431, RHEUMATOID FACTOR QUANTITATIVE,84550, URIC ACID BLOOD,0005-149902-1021, CLOFEN -(DICLOFENAC SODIUM : 75 MG/3ML) SOLUTION FOR INJECTION,96372, THER/PROPH/DIAG INJ SC/IM,101, GENARAL WELNES CHECKUP (55 TEST),9, Consultation GP **Estimated Cost** :

Prescriptions: 0027-142201-0831 - (DICLOFENAC POTASSIUM : 50 MG) POWDER FOR SOLUTION,1217-373201-2401 - (TOLPERISONE : 150 MG) SUGAR COATED TABLETS,2093-596002-0432 - (DICLOFENAC DIETHYLAMINE : 23.2 MG / G) GEL,1190-170813-1161 - (LACTULOSE : 667MG/G) SYRUP, **Estimated Cost** :

MEDICAL PRACTITIONER DECLARATION :

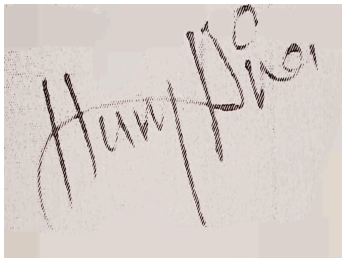
I declare that I am the patient's medical practitioner and that the particulars given are to the best of my knowledge true and correct.

Dr's Name : Humaira

Stamp :

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

Signature :



Date : 24-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 : 24-Jul-2024