Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	**: Amine Boufouss**
Card No	**: I005-029-118846267-01**
Policy Holder	**: Amine Boufouss**
Payer Name	**: DUBAI INSURANCE COMPANY**
TPA	**: E CARE - Blue Network**
Validity	**: 16-11-2023** To **15-11-2024**
Gender	**: Male**
Date Of Birth	**: 27-Mar-2001**
Patient's Tel No	**: 0522373620**

Service Date **:02-Aug-2024** **Network** **:** Green

Health Provider **:CITICARE MEDICAL CENTER LLC** **Direct Access SP - YES**

Doctor's Name **:Humaira**

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 : co fever on and off both hand joint pain dry cough nose is blocked 29th july 2024 oe enlarge tonsills chest is congested no added sounds restless taking tablet at home penadol **Duration:**

Vitals: Temp : 36.8 Bp :108 Pulse :58 Resp :18

Clinical Findings:

Diagnosis: R50.9 - Fever, unspecified,R05 - Cough,J06.9 - Acute upper respiratory infection, unspecified, **Date of Onset :**02/15/2024

Requested Investigations: 85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,85652, SEDIMENTATION RATE RBC AUTOMATED,86140, C REACTIVE PROTEIN,0195-107704-0801, CEFTRIAXONE-TABUK IV,96365, THER/PROPH/DIAG IV INF INIT,0188-135906-2441, PULMICORT-(BUDESONIDE : 0.5 MG/ML) SUSPENSION FOR NEBULIZATION,94640, AIRWAY INHALATION TREATMENT,9, Consultation GP **Estimated Cost :**

Prescriptions: 0097-393801-2471 - (AMMONIUM CHLORIDE : 131.5 MG/5 ML) (DIPHENHYDRAMINE HCL : 13.5 MG/5ML) SYRUP (ALCOHOL FREE),0005-107001-0051 - (CAFFEINE : 65 MG) (PARACETAMOL : 500 MG) CAPLETS,0139-116206-1171 - (CLAVULANIC ACID : 125 MG) (AMOXICILLIN : 875 MG) TABLETS,0195-123701-0391 - (CETIRIZINE HCL : 10 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.

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.

Dr's Name **:** Humaira

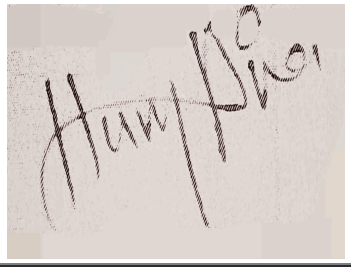
Stamp :

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

Patient 's signature{Parent if minor} **:**

Date : 02-Aug-2024

Signature :



Date **:** 02-Aug-2024