Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name : **MUHAMMAD BAHIR**
Card No : **I022-029-114042580-01**
Policy Holder : **MUHAMMAD BAHIR**
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**

Service Date :**19-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 : fever and generalized body pain headache. and weakness. **Duration :**

Vitals:

Clinical Findings:

Diagnosis: R50.9 - Fever, unspecified,R51.9 - Headache, unspecified, **Date of Onset** :19/47/2024

Requested Investigations: 9, Consultation GP **Estimated Cost** :

Prescriptions: **Estimated Cost** :

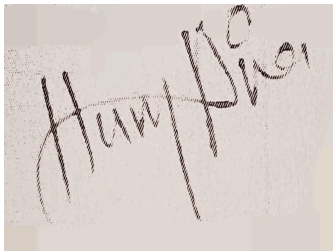
MEDICAL PRACTITIONER DECLARATION :

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 : Humaira

Stamp :

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

Signature : 

Date : 19-Aug-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 : 19-Aug-2024