Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	: **MARINA CHSHERBAKOVA**	**Service Date**	**:22-Aug-2024** **Network** : Green
Card No	: **I022-029-121173031-01**	**Health Provider**	**:CITICARE MEDICAL CENTER LLC** **Direct Access SP - YES**
Policy Holder	: **MARINA CHSHERBAKOVA**	**Doctor's Name**	**:Humaira**
Payer Name	: **TAKAFUL EMARAT**	**Co-Insurance**	:
TPA	: **E CARE - Green Network**	**Remarks**	:
Validity	: **09-08-2024** To **08-08-2025**		
Gender	: **Female**		
Date Of Birth	: **07-Sep-1989**		
Patient's Tel No	: **0588875340**		

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 nasal blockage irritation in the throat 19th august 2024 oe chest is clear no added sounds stable **Duration:**

Vitals: Temp : 37.4 Bp :108 Pulse :74 Resp :20

Clinical Findings:

Diagnosis: J30.9 - Allergic rhinitis, unspecified,R22.0 - Localized swelling, mass and lump, head, **Date of Onset** :22/12/2024

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

Prescriptions: 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.

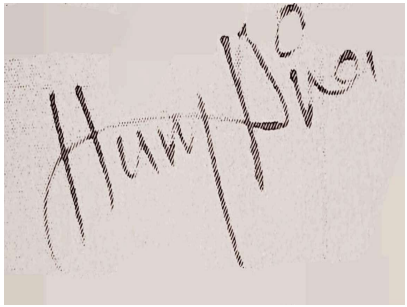
Dr's Name : Humaira

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 : 22-Aug-2024

Signature : 

Date : 22-Aug-2024