Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	: **JANE FRANCIS CABALLES DE REAL**	**Service Date**	:**03-Sep-2024** **Network** : Green
Card No	: **I022-029-120411590-01**	**Health Provider**	:**CITICARE MEDICAL CENTER LLC** **Direct Access SI**
Policy Holder	: **JANE FRANCIS CABALLES DE REAL**	**Doctor's Name**	:**Humaira**
Payer Name	: **TAKAFUL EMARAT**		
TPA	: **E CARE - Blue Network**		
Validity	: **03-07-2024** To **02-07-2025**		
Gender	: **Female**	**Remarks**	:
Date Of Birth	: **16-Dec-1984**		
Patient's Tel No	: **0586276930**		

Co-Insurance :

CONSULTATION	LAB/ RADIOLOGY	PHYSIO	PHARMACY	IP	MATEF
10% max	NIL	NIL	NIL LIMIT	NIL	10%

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

Chief Complaints : **Duration** :

Vitals:

Clinical Findings:

Diagnosis: R50.9 - Fever, unspecified,J03.91 - Acute recurrent tonsillitis, unspecified,J06.9 - Acute upper respiratory infection, unspecified,K29.00 - Acute gastritis without bleeding,R05 - Cough, **Date of Onset**

Requested Investigations: 96365, THER/PROPH/DIAG IV INF INIT,9.01, Follow Up Consultation GP,0195-107704-0801, CEFTRIAXONE-TABUK 1 GM IV,86140, C REACTIVE PROTEIN **Estimated Cost** :

Estimated Cost :

Prescriptions:

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 :

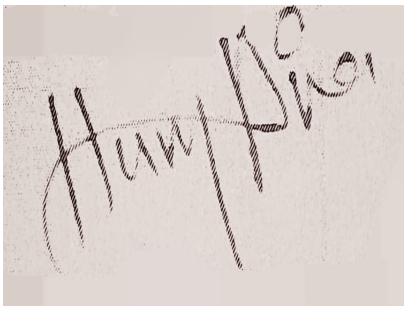
I hereby authorize any Healthcar or other organization to release a medical condition & history for p insurance benefits.

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} :

Signature :  **Date :** 03-Sep-2024