Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	: MAHROSH ZAHID	**Service Date**	:03-Sep-2024
Card No	: I022-029-120554468-01	**Health Provider**	:CITICARE MEDICAL CENTER LLC
Policy Holder	: MAHROSH ZAHID	**Doctor's Name**	:Enomen Goodluck
Payer Name	: TAKAFUL EMARAT		
TPA	: E CARE - Blue Network		
Validity	: 08-03-2024 To 07-03-2025		
Gender	: Female		
Date Of Birth	: 12-Jul-2020		
Patient's Tel No	: 0544047084		

Network : Green

Direct Access SP

Co-Insurance :

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

Remarks :

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

Chief Complaints : Fever and cough since last night. **Duration** :

Vitals: Temp : 38.3 Bp :0 Pulse :0 Resp :24

Clinical Findings:

Diagnosis: J02.9 - Acute pharyngitis, unspecified,R50.9 - Fever, unspecified,R05 - Cough, **Date of Onset** :

Estimated Cost :

Requested Investigations: 9, Consultation GP

Prescriptions: 1086-123702-1381 - (CETIRIZINE HCL : 1 MG/ML) SOLUTION (ORAL),0102-106704-1161 - (CHLORPHENIRAMINE : 0.75 MG/5 ML) (PARACETAMOL : 120 MG/5ML) (PSEUDOEPHEDRINE : 15 MG/5ML) SYRUP,1516-106606-1161 - (PARACETAMOL : 250 MG/5ML) SYRUP,0027-149905-2231 - (DICLOFENAC SODIUM : 12.5 MG) RECTAL SUPPOSITORIES,

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 :

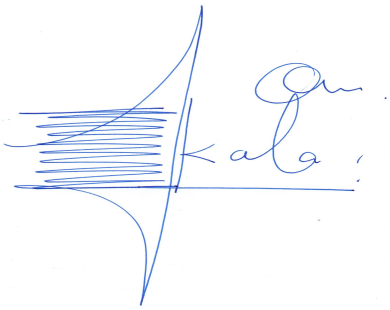
I hereby authorize any Healthcar or other organization to release a medical condition & history for p insurance benefits.

Dr's Name : Enomen Goodluck

Stamp :

Dr. Enomen Goodluck Ekata
General Practitioner
DHA No: 28040827-001
CITICARE MEDICAL CENTER LLC
DUBAI - U.A.E.

Patient 's signature{Parent if minor} :

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