Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	: **ALI ISMAIL ABBOUD**
Card No	: **I022-029-120838063-01**
Policy Holder	: **ALI ISMAIL ABBOUD**
Payer Name	: **TAKAFUL EMARAT**
TPA	: **E CARE - Green Network**
Validity	: **13-05-2024** To **13-05-2025**
Gender	: **Male**
Date Of Birth	: **15-Jan-1989**
Patient's Tel No	: **0506011301**

Service Date :**11-Sep-2024** **Network** : Green

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

Doctor's Name :**AHSAN HUSSAIN**

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 running nose cough prulant 3rd sep. 2024 oe chest is wheezing restless smoker alcohol **Duration:**

Vitals: Temp : 36.9 Bp :127 Pulse :87 Resp :18

Clinical Findings:

Diagnosis: R50.9 - Fever, unspecified,J06.9 - Acute upper respiratory infection, unspecified,R05 - Cough,K29.00 - Acute gastritis without bleeding, **Date of Onset** :11/23/2024

Requested Investigations: 94640, AIRWAY INHALATION TREATMENT,0188-135906-2441, PULMICORT,0195-107704-0801, CEFTRIAXONE-TABUK IV,96365, THER/PROPH/DIAG IV INF INIT,9.01, Follow Up 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.

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 : AHSAN HUSSAIN

Stamp :

Dr. Ahsan Hussain
General Practitioner
DHA No: 87543658-001
CITICARE MEDICAL CENTER LLC
DUBAI - U.A.E.

Patient 's signature{Parent if minor} :

Date : 11-Sep-2024

Signature :

Date : 11-Sep-2024