Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	**: ZIZWEZOSUKUMA JOSE MBATHA**
Card No	**: 784-2012-5094149-5**
Policy Holder	**: ZIZWEZOSUKUMA JOSE MBATHA**
Payer Name	**: TAKAFUL EMARAT**
TPA	**: E CARE - Blue Network**
Validity	**: 10-05-2024** To **09-05-2025**
Gender	**: Male**
Date Of Birth	**: 05-May-2012**
Patient's Tel No	**: 0529717233**

Service Date :24-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 : PC: HISTORY OF FALL WHILE PLAYING AROUND 4 PM ANKLE SPRINT INFLAMATION AROUND ANKLE JOINT RIGHT FEET **Duration:**

Vitals: Temp : 36.8 Bp :90 Pulse :52 Resp :18

Clinical Findings:

Diagnosis: S93.491A - Sprain of other ligament of right ankle, initial encounter,M25.571 - Pain in right ankle and joints of right foot, **Date of Onset** :24/11/2024

Estimated Cost :

Requested Investigations: 9, Consultation GP

Prescriptions: 0046-159501-0341 - (SERRATIOPEPTIDASE : 5 MG) ENTERIC COATED TABLETS,4885-107902-0971 - (IBUPROFEN : 400 MG) SOFT GELATIN CAPSULES, **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 : AHSAN HUSSAIN **Stamp :**

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

Signature : **Date** : 24-Sep-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 :** 24-Sep-2024