Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	: Arley Arboleda Munoz	**Service Date**	:05-Oct-2024
Card No	: I022-029-120520274-01	**Health Provider**	:CITICARE MEDICAL CENTER LLC
Policy Holder	: Arley Arboleda Munoz	**Doctor's Name**	:Humaira
Payer Name	: TAKAFUL EMARAT	**Co-Insurance**	:
TPA	: E CARE - Blue Network		
Validity	: 29-02-2024 To 27-02-2025		
Gender	: Male	**Remarks**	:
Date Of Birth	: 24-Apr-1985		
Patient's Tel No	: 0561790894		

Network : Green

Direct Access SP - YES

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 painful micturation dark colour of urine fever on and off burning of the urine 24th sep. 2024 oe chest is clear no added sounds restless **Duration:**

Vitals: Temp : 36.4 Bp :130 Pulse :60 Resp :18

Clinical Findings:

Diagnosis: N39.0 - Urinary tract infection, site not specified,R50.9 - Fever, unspecified,R30.9 - Painful micturition, unspecified, **Date of Onset** :05/35/2024

Requested Investigations: 85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,86140, C REACTIVE PROTEIN,81001, URNLS DIP STICK/TABLET REAGENT AUTO MICROSCOPY,0102-152902-1001, LACTATED RINGERS INJECTION USP,96360, HYDRATION IV INFUSION INIT,0002-116601-1001, METRONIDAZOLE : 500 MG/100ML) SOLUTION FOR INFUSION ,30042033, CIPROFLOXACIN,96365, IV INFUSION THERAPY -Antibiotics & Others,9, Consultation GP,96374, THER/PROPH/DIAG INJ IV PUSH,2190-106618-1001, PARAFUSIV **Estimated Cost** :

Prescriptions: 0005-107001-0051 - (CAFFEINE : 65 MG) (PARACETAMOL : 500 MG) CAPLETS,0097-658501-0251 - (TARTARIC ACID : 0.89G) (SODIUM BICARBONATE : 1.76G) (CRANBERRY EXTRACT : 0.25 G) (TRI SODIUM CITRATE ANHYDROUS : 0.63G) (CITRIC ACID ANHYDROUS : 0.72G) EFFERVESCENT GRANULES,0195-116604-0391 - (METRONIDAZOLE : 500 MG) FILM COATED TABLETS,0102-103201-0391 - (CIPROFLOXACIN : 500 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

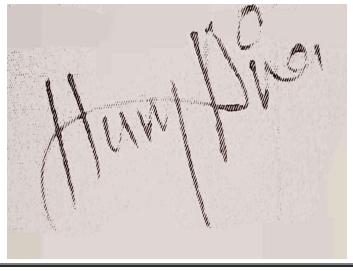
Stamp :

Dr. Humaira Mumtaz
General Practitioner
DHA No: 54155530-002
CITICARE MEDICAL CENTER LLC
DUBAI - U.A.E.

Patient 's signature{Parent if minor} :

Date : 05-Oct-2024

Signature :



Date : 05-Oct-2024