Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name : MANJUSHA ADLAKHA NARAYAN LAL ADLAKHA
Card No : R6604522
Policy Holder : MANJUSHA ADLAKHA NARAYAN LAL ADLAKHA
Payer Name : TAKAFUL EMARAT
TPA : E CARE - Blue Network
Validity : 31-07-2024 To 30-07-2025
Gender : Female
Date Of Birth : 17-Oct-1979
Patient's Tel No : 0523668349

Service Date :06-Oct-2024
Health Provider :CITICARE MEDICAL CENTER LLC
Doctor's Name :AHSAN HUSSAIN
Network : Green
Direct Access SP - YES

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: PAIN IN LEFT EAR FUNGAL INFECTION BOTH EARS **Duration :**

Vitals: Temp : 36.6 Bp :108 Pulse :76 Resp :18

Clinical Findings:

Diagnosis: H60.513 - Acute actinic otitis externa, bilateral,R52 - Pain, unspecified, **Date of Onset** :06/18/2024

Estimated Cost :

Requested Investigations: 9, Consultation GP

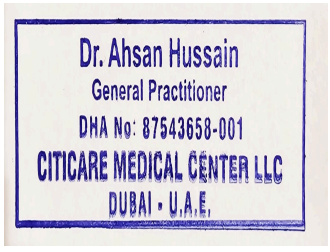
Estimated Cost :

Prescriptions: 0609-280801-0241 - (PHENAZONE : 50 MG/ML) EAR DROPS,

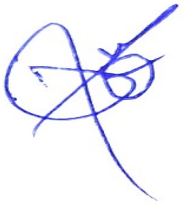
MEDICAL PRACTITIONER DECLARATION :

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 :**



Signature :



Date : 06-Oct-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 : 06-Oct-2024