Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	: MOHAMMAD YOUSAF	**Service Date**	:30-Oct-2024
Card No	: I022-029-120869898-01	**Health Provider**	:CITICARE MEDICAL CENTER LLC
Policy Holder	: MOHAMMAD YOUSAF	**Doctor's Name**	:Humaira
Payer Name	: TAKAFUL EMARAT		
TPA	: E CARE - Blue Network		
Validity	: 03-06-2024 To 02-06-2025		
Gender	: Male		
Date Of Birth	: 20-Apr-1994		
Patient's Tel No	: 0542791377		

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 : co small nodules on the penis from one month sep2024 oe chest is clear no added sounds restless **Duration:**

Vitals: Temp : 36.9 Bp :132 Pulse :94 Resp :18

Clinical Findings:

Diagnosis: C84.00 - Mycosis fungoides, unspecified site, **Date of Onset** : 30/27/2024

Requested Investigations: 0122, STD SEXUAL TRANSMITTED DISEASES SCREEN II,9, Consultation GP **Estimated Cost** :

Prescriptions: 0159-140504-0151 - (CLOTRIMAZOLE : 1% CREAM, **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

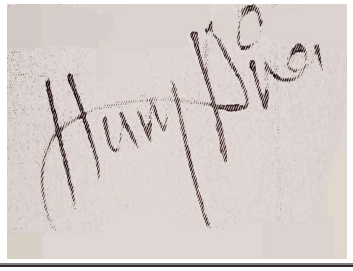
Stamp :

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

Patient 's signature{Parent if minor} :

Date : 30-Oct-2024

Signature :



Date : 30-Oct-2024