Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	: LUDEK SAFRANEK	**Service Date**	:15-Nov-2024
Card No	: I022-029-120877992-01	**Health Provider**	:CITICARE MEDICAL CENTER LLC
Policy Holder	: LUDEK SAFRANEK	**Doctor's Name**	:Humaira
Payer Name	: TAKAFUL EMARAT	**Co-Insurance**	:
TPA	: E CARE - Blue Network	**Remarks**	:
Validity	: 04-06-2024 To 03-06-2025		
Gender	: Male		
Date Of Birth	: 05-Oct-1983		
Patient's Tel No	: 0585085235		

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 sometimes blood pressure is increased heavyness in the chest on and off **Duration:**
8th nov. 2024 oe chest is clear no added sounds restless

Vitals: Temp : 36.5 Bp :110 Pulse :86 Resp :18

Clinical Findings:

Diagnosis: R07.9 - Chest pain, unspecified, **Date of Onset** : 15/33/2024

Estimated Cost :

Requested Investigations: 9, Consultation GP,80061, LIPID PANEL

Estimated Cost :

Prescriptions:

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

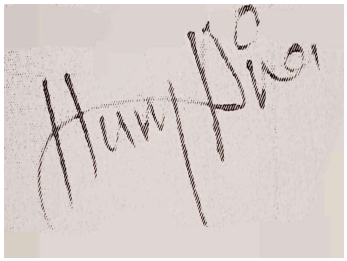
Stamp :

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

Patient 's signature{Parent if minor} :

Date : 15-Nov-2024

Signature :



Date : 15-Nov-2024