Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	**: LUDEK SAFRANEK**	**Service Date**	**:15-Nov-2024**	**Network**	**:** Green
Card No	**: I022-029-120877992-01**	**Health Provider**	**:CITICARE MEDICAL CENTER LLC**		**Direct Access SP - YES**
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**				

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,E78.5 - Hyperlipidemia, unspecified, **Date of Onset :** 20/04/2024

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.

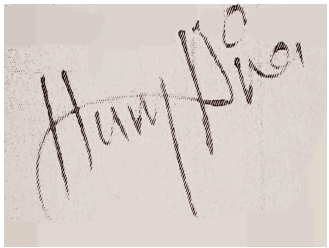
PATIENT'S DECLARATION :

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 :** 20-Nov-2024

Signature :  **Date :** 20-Nov-2024