Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	: **KASSEM CHABAYTA**	**Service Date**	:**27-Nov-2024**
Card No	: **I022-029-114042578-01**	**Health Provider**	:**CITICARE MEDICAL CENTER LLC**
Policy Holder	: **KASSEM CHABAYTA**	**Doctor's Name**	:**Humaira**
Payer Name	: **TAKAFUL EMARAT**	**Co-Insurance**	:
TPA	: **E CARE - Blue Network**	**Validity**	: **30-08-2024** To **29-08-2025**
Gender	: **Male**	**Remarks**	:
Date Of Birth	: **16-Nov-1986**		
Patient's Tel No	: **0568875264**		

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 blood in the urine pain inthe lower abdominal region 25th nov. 2024 oe chest is clear no added sounds restless smoker **Duration:**

Vitals: Temp : 35.7 Bp :100 Pulse :86 Resp :18

Clinical Findings:

Diagnosis: N39.0 - Urinary tract infection, site not specified,R10.30 - Lower abdominal pain, unspecified,R52 - Pain, unspecified, **Date of Onset** :09/19/2024

Requested Investigations: 85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,86140, C REACTIVE PROTEIN,81001, URNLS DIP STICK/TABLET REAGENT AUTO MICROSCOPY,0005-136504-1021, SCOPINAL,0102-111908-1001, SODIUM CHLORIDE B.P.,96360, HYDRATION IV INFUSION INIT,96372, THER/PROPH/DIAG INJ SC/IM,9, Consultation GP,30042033, CIPROFLOXACIN,INJ060, INJ-METRONIDAZOLE 500 MG/100ML - IV **Estimated Cost** :

Prescriptions: 0005-136501-0392 - (HYOSCINE : 10 MG) FILM COATED TABLETS,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,3114-482003-0391 - (CIPROFLOXACIN (AS HYDROCHLORIDE) : 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

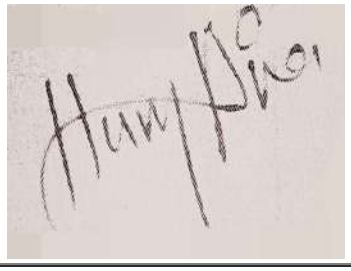
Stamp :

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

Patient 's signature{Parent if minor} :

Date : 09-Dec-2024

Signature :



Date : 09-Dec-2024