Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name : KASSEM CHABAYTA
Card No : I022-029-114042578-01
Policy Holder : KASSEM CHABAYTA
Payer Name : TAKAFUL EMARAT
TPA : E CARE - Blue Network
Validity : 30-08-2024 To 29-08-2025
Gender : Male
Date Of Birth : 16-Nov-1986
Patient's Tel No : 0568875264

Service Date :29-Nov-2024 **Network** : Green
Health Provider :CITICARE MEDICAL CENTER LLC **Direct Access SP - YES**
Doctor's Name :Humaira

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 : **Duration** :

Vitals:

Clinical Findings:

Diagnosis: N39.0 - Urinary tract infection, site not specified,R10.30 - Lower abdominal pain, unspecified,R52 - Pain, unspecified, **Date of Onset** :29/23/2024

Estimated Cost :

Requested Investigations: 9.01, Follow Up Consultation GP

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

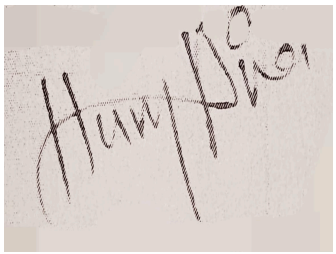
Stamp :

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

Patient 's signature{Parent if minor} :

Date : 29-Nov-2024

Signature :



Date : 29-Nov-2024