Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	**: CHARLES PHILIP TAYLOR**	**Service Date**	**:03-Dec-2024** **Network** : Green
Card No	**: I022-029-121735273-01**	**Health Provider**	**:CITICARE MEDICAL CENTER LLC** **Direct Access SP - YES**
Policy Holder	**: CHARLES PHILIP TAYLOR**	**Doctor's Name**	**:Humaira**
Payer Name	**: TAKAFUL EMARAT**		
TPA	**: E CARE - Blue Network**	**Co-Insurance**	:
Validity	**: 25-11-2024** To **24-11-2025**		
Gender	**: Male**	**Remarks**	:
Date Of Birth	**: 25-Jul-1995**		
Patient's Tel No	**: 0565542809**		

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 pain in throat pain in joint knee 1st dec. 2024 oe chest is clear no added sounds restless **Duration:**

Vitals: Temp : 36 Bp :110 Pulse :86 Resp :18

Clinical Findings:

Diagnosis: M25.569 - Pain in unspecified knee, **Date of Onset** : 03/01/2024

Estimated Cost :

Requested Investigations: 9, Consultation GP

Prescriptions: 0250-125808-1741 - (POVIDONE IODINE : 1%) GARGLE,0278-107903-0391 - (IBUPROFEN : 600 MG) FILM COATED TABLETS,2093-596002-0432 - (DICLOFENAC DIETHYLAMINE : 23.2 MG / G) GEL,

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.

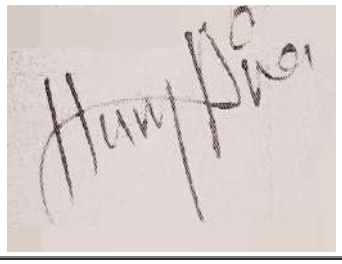
PATIENT'S DECLARATION :

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** : 03-Dec-2024

Signature :  **Date** : 03-Dec-2024