Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	: **MUHAMMAD BAHIR**	**Service Date**	:**14-Dec-2024**
Card No	: **I022-029-114042580-01**	**Health Provider**	:**CITICARE MEDICAL CENTER LLC**
Policy Holder	: **MUHAMMAD BAHIR**	**Doctor's Name**	:**Enomen Goodluck**
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-Jun-1990**		
Patient's Tel No	: **765697144**		

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 : **Duration :**

Vitals:

Clinical Findings:

Diagnosis: J02.9 - Acute pharyngitis, unspecified,J01.10 - Acute frontal sinusitis, unspecified,M79.10 - Myalgia, unspecified site,E86.0 - Dehydration,R05 - Cough,R53.1 - Weakness,R51.9 - Headache, unspecified, **Date of Onset** :18/56/2024

Requested Investigations: 9.01, Follow Up Consultation GP,96360, HYDRATION IV INFUSION INIT,0102-100104-1001, SODIUM CHLORIDE & DEXTROSE B.P.,96372, THER/PROPH/DIAG INJ SC/IM,0005-149902-1021, CLOFEN ,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE **Estimated Cost** :

Prescriptions: **Estimated Cost** :

MEDICAL PRACTITIONER DECLARATION :

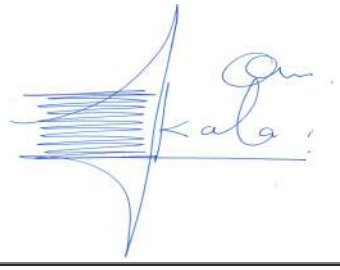
I declare that I am the patient's medical practitioner and that the particulars given are to the best of my knowledge true and correct.

Dr's Name : Enomen Goodluck

Stamp :

Dr. Enomen Goodluck Ekata
General Practitioner
DHA No: 28040827-001
CITICARE MEDICAL CENTER LLC
DUBAI - U.A.E.

Signature :



Date : 18-Dec-2024

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.

Patient 's signature{Parent if minor} :

Date : 18-Dec-2024