Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	: **PARTHIV DEWAN DINESH DEWAN**	**Service Date**	:**14-Dec-2024**
Card No	: **I022-029-115720168-01**	**Health Provider**	:**CITICARE MEDICAL CENTER LLC**
Policy Holder	: **PARTHIV DEWAN DINESH DEWAN**	**Doctor's Name**	:**AHSAN HUSSAIN**
Payer Name	: **TAKAFUL EMARAT**	**Co-Insurance**	:
TPA	: **E CARE - Blue Network**	**Remarks**	:
Validity	: **12-09-2024** To **11-09-2025**		
Gender	: **Male**		
Date Of Birth	: **17-Feb-1993**		
Patient's Tel No	: **971551709377**		

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 : pc: numbness in your left arm chest pain on breathing history of hyperlipidemia **Duration:**

Vitals: Temp : 36 Bp :122 Pulse :64 Resp :18

Clinical Findings:

Diagnosis: R07.9 - Chest pain, unspecified,E78.5 - Hyperlipidemia, unspecified,M62.830 - Muscle spasm of back, **Date of Onset:**18/37/2024

Requested Investigations: 80061, LIPID PANEL,93000, ELECTROCARDIOGRAM COMPLETE,9, Consultation GP **Estimated Cost** :

Prescriptions: 1217-373201-2401 - (TOLPERISONE : 150 MG) SUGAR 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 : AHSAN HUSSAIN **Stamp :**

Patient 's signature{Parent if minor} : **Date :** 18-Dec-2024

Signature : **Date** : 18-Dec-2024