

Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name : ISLAM HAFSI
Card No : I022-029-120338346-01
Policy Holder : ISLAM HAFSI
Payer Name : TAKAFUL EMARAT
TPA : E CARE - Blue Network
Validity : 17-01-2024 To 16-01-2025
Gender : Female
Date Of Birth : 07-Oct-1988
Patient's Tel No : 0521706901

Service Date :23-Dec-2024
Health Provider :CITICARE MEDICAL CENTER LLC
Doctor's Name :SANDIA

Network : Green
Direct Access SP - YES

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 : pt looks dehydrated, pt comes with tiredness, throat pain, runny nose since 2 days. cough started this morning. cough is productive. no fever but complains of fatigue and looks lethargic on exam throat looks inflamed and chest congestion.

Vitals:Temp : 36.4 Bp :110 Pulse :64 Resp :18

Clinical Findings:

Diagnosis: R07.0 - Pain in throat,R05 - Cough,J30.9 - Allergic rhinitis, unspecified,R53.83 - Other fatigue,E86.0 - Dehydration, **Date of Onset** :23/42/2024

Requested Investigations: 96360, HYDRATION IV INFUSION INIT,0102-100104-1001, SODIUM CHLORIDE & DEXTROSE B.P.,9, Consultation GP **Estimated Cost** :

Prescriptions: 7864-040901-1161 - (ACEROLA : 0.4 %/150ML) (SISYMBRIUM OFFICINALE : 0.2 %/150ML) (THYMUS VULGARIS EXTRACT : 0.4 %/150ML) (MALVA SYLVESTRIS : 0.2 %/150ML) (EUCALYPTUS OIL : 0.1 %/150ML) (PROPOLIS EXTRACT : 0.4 %/150ML) (ACACIA HONEY : 5 %/150ML) SYRUP,0252-185801-0391 - (DIPHENHYDRAMINE : 25 MG (PARACETAMOL : 500 MG (PSEUDOEPHEDRINE : 30 MG FILM COATED TABLETS,0139-116207-1171 - (CLAVULANIC ACID : 125 MG) (AMOXICILLIN : 500 MG) 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 :

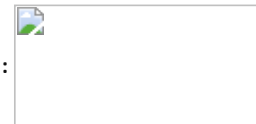
I hereby authorize any Healthcare provider, Insurer, Employer or other organization to release any information regarding my medical condition & history for purpose of determining insurance benefits.

Dr's Name : SANDIA

Stamp :



Patient's signature{Parent : if minor}



Date : Dec-2024

Signature :

Date : 23-Dec-2024