Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	: MUHAMMAD BAHIR	**Service Date**	:30-Dec-2024
Card No	: I022-029-114042580-01	**Health Provider**	:CITICARE MEDICAL CENTER LLC
Policy Holder	: MUHAMMAD BAHIR	**Doctor's Name**	:Humaira
Payer Name	: TAKAFUL EMARAT		
TPA	: E CARE - Blue Network		
Validity	: 30-08-2024 To 29-08-2025		
Gender	: Male		
Date Of Birth	: 16-Jun-1990		
Patient's Tel No	: 765697144		

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 : PC: Pain in throat, cough and headache with body pains,. Duration: one week 25/12/2024 **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** :30/07/2024

Requested Investigations: 9, Consultation GP,96365, THER/PROPH/DIAG IV INF INIT,0195-107704-0801, CEFTRIAXONE-TABUK IV,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE,96372, THER/PROPH/DIAG INJ SC/IM **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.

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.

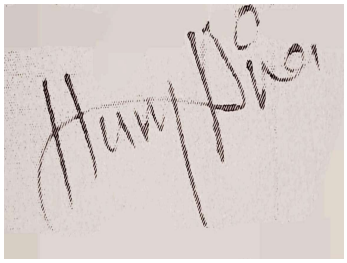
Dr's Name : Humaira

Stamp :

Patient 's signature{Parent if minor} :

Date : 30-Dec-2024

Signature :



Date : 30-Dec-2024