Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	: **YASMINE OMER AKEEL ABDUL WAHAB**	**Service Date**	:**21-Jan-2025** **Network** : Green
Card No	: **I022-029-116140261-01**	**Health Provider**	:**CITICARE MEDICAL CENTER LLC** **Direct Access SP - YES**
Policy Holder	: **YASMINE OMER AKEEL ABDUL WAHAB**	**Doctor's Name**	:**Humaira**
Payer Name	: **TAKAFUL EMARAT**	**Co-Insurance:**	
TPA	: **E CARE - Blue Network**	**Remarks**	:
Validity	: **31-10-2024** To **30-10-2025**		
Gender	: **Female**		
Date Of Birth	: **15-Sep-2015**		
Patient's Tel No	: **0505970314**		

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 fever on and off body ACHE headache 19th jan. 2025 oe chest is clear no added sounds restless **Duration:**

Vitals: Temp : 38.6 Bp :0 Pulse :86 Resp :24

Clinical Findings:

Diagnosis: J06.0 - Acute laryngopharyngitis,R50.9 - Fever, unspecified,R52 - Pain, unspecified, **Date of Onset** :21/24/2025

Requested Investigations: 9, Consultation GP,8787, VOLTAREN SUPPOSITORY **Estimated Cost** :

Prescriptions: 0005-106604-1162 - (PARACETAMOL : 120 MG/5ML) SYRUP, **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.

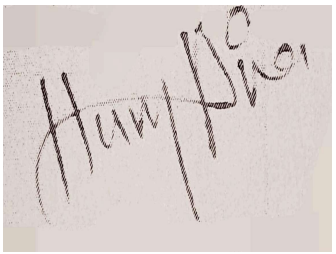
PATIENT'S DECLARATION :

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 :** 21-Jan-2025

Signature :  **Date** : 21-Jan-2025