

Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name : Henry Haddad

Service Date :23-Jan-2025

Network : Green

Card No : I022-029-115842325-01

Health
Provider :CITICARE MEDICAL CENTER LLC

Direct Access SP - YES

Policy Holder : Henry Haddad

Doctor's
Name :DR Amaizah

Payer Name : TAKAFUL EMARAT

TPA : E CARE - Blue Network

Validity : 15-08-2024 To
14-08-2025

Co-Insurance :

CONSULTATION	LAB/ RADIOLOGY	PHYSIO	PHARMACY	IP	MATERNITY	DENTAL
10% max	NIL	NIL	NIL LIMIT	NIL	10%	NA

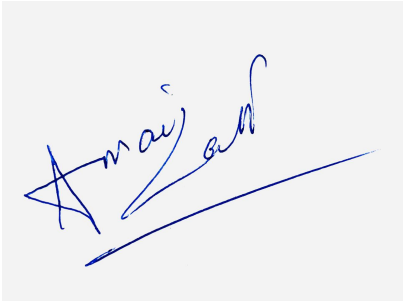
Gender : Male

Date Of Birth : 13-Sep-1980

Remarks :

Patient's Tel
No : 0526997720

☐ Acute	☐ Pre-existing and chronic	☐ Maternity
Chief Complaints : pc : swollen lid itching pain swollen lips no other med conditions o/e styel Duration:		
Vitals: Temp : 36.8 Bp :118 Pulse :80 Resp :20		
Clinical Findings:		
Diagnosis: R21 - Rash and other nonspecific skin eruption,		Date of Onset : 23/53/2025
Requested Investigations: 85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,86140, C REACTIVE PROTEIN,86005, ALLERGEN SPECIFIC IGE QUAL MULTIALLERGEN SCREEN,9, Consultation GP		Estimated : Cost
Prescriptions: 0085-217401-0381 - (DEXAMETHASONE : 1 MG/G (NEOMYCIN : 3500 IU/G (POLYMYXIN B : 6000 IU/G EYE OINTMENT,0138-169101-1452 - (DOXYCYCLINE : 100 MG CAPSULES (HARD GELATIN,0195-123701-0391 - (CETIRIZINE HCL : 10 MG FILM 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. Dr's : DR Amaizah Name		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. Stamp :

Dr. Amaizah Ishtiaq General Practitioner DHA: 98486553-001 CITICARE MEDICAL CENTER DUBAI - U.A.E		Patient 's signature{Parent : if minor}		Date : 23- Jan-2025
Signature :		Date : 23-Jan-2025		