

Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name : JANE FRANCIS CABALLES DE REAL
Card No : I022-029-120411590-01
Policy Holder : JANE FRANCIS CABALLES DE REAL
Payer Name : TAKAFUL EMARAT
TPA : E CARE - Blue Network
Validity : 03-07-2024 To 02-07-2025
Gender : Female
Date Of Birth : 16-Dec-1984
Patient's Tel No : 0586276930

Service Date : 27-Jan-2025
Health Provider : CITICARE MEDICAL CENTER LLC
Doctor's Name : Humaira

Network : Green
Direct Access SP - YES

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

Co-Insurance :

Remarks :

☐ Acute
 ☐ Pre-existing and chronic
 ☐ Maternity

Chief Complaints : co fever on and off dry cough running nose 24th jan. 2025 oe chest is congested no added sounds restless

Duration:

Vitals:Temp : 37.4 Bp :140 Pulse :88 Resp :18

Clinical Findings:

Diagnosis: J06.9 - Acute upper respiratory infection, unspecified, J30.9 - Allergic rhinitis, unspecified, R05 - Cough, R50.9 - Fever, unspecified, K29.00 - Acute gastritis without bleeding,

Date of Onset : 27/10/2025

Requested Investigations: 85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT, 86140, C REACTIVE PROTEIN, 0188-135906-2441, PULMICORT-(BUDESONIDE : 0.5 MG/ML) SUSPENSION FOR NEBULIZATION, 94640, AIRWAY INHALATION TREATMENT, 2190-106618-1001, PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION, 0195-107704-0801, CEFTRIAXONE-TABUK IV, 96365, THER/PROPH/DIAG IV INF INIT, 9, Consultation GP, 96374, THER/PROPH/DIAG INJ IV PUSH

Estimated : Cost

Prescriptions: 0005-119803-1171 - (PREDNISOLONE : 20 MG TABLETS, 0195-123701-0391 - (CETIRIZINE HCL : 10 MG) FILM COATED TABLETS, 0139-116206-1171 - (CLAVULANIC ACID : 125 MG) (AMOXICILLIN : 875 MG) TABLETS, 0207-533801-1451 - (ESOMEPRAZOLE (AS MAGNESIUM) : 20 MG) CAPSULES (HARD GELATIN), 0097-393801-2471 - (AMMONIUM CHLORIDE : 131.5 MG/5 ML) (DIPHENHYDRAMINE HCL : 13.5 MG/5ML) SYRUP (ALCOHOL FREE), 0724-107002-1171 - (CAFFEINE : 60 MG) (PARACETAMOL : 500 MG) TABLETS,

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 :

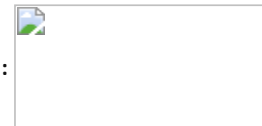
I hereby authorize any Healthcare provider, Insurer, Employer or other organization to release any information regarding my medical condition & history for purpose of determining insurance benefits.

Dr's Name : Humaira

Stamp :



Patient's signature {Parent : if minor}



Date : 27-Jan-2025

Signature :

Date : 27-Jan-2025