Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	: VALLARI VIJAY POHARKAR	**Service Date**	:28-Jan-2025
Card No	: I022-029-121894114-01	**Health Provider**	:CITICARE MEDICAL CENTER LLC
Policy Holder	: VALLARI VIJAY POHARKAR	**Doctor's Name**	:DR Amaizah
Payer Name	: TAKAFUL EMARAT	**Co-Insurance**	:
TPA	: E CARE - Blue Network	**Remarks**	:
Validity	: 25-12-2024 To 24-12-2025		
Gender	: Female		
Date Of Birth	: 03-Jan-1996		
Patient's Tel No	: +919112222334		

Network : Green

Direct Access SP - YES

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 : **Duration** :

Vitals: Temp : 36 Bp :110 Pulse :86 Resp :18

Clinical Findings:

Diagnosis: N13.2 - Hydronephrosis with renal and ureteral calculous obstruction,R11.2 - Nausea with vomiting, unspecified,

Date of Onset :28/14/2025

Estimated Cost :

Requested Investigations: 9.01, Follow Up Consultation GP

Estimated Cost :

Prescriptions:

MEDICAL PRACTITIONER DECLARATION :

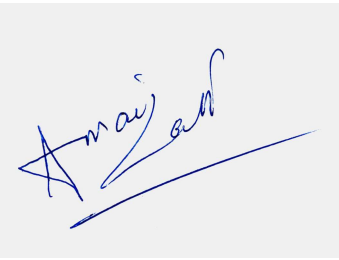
I declare that I am the patient's medical practitioner and that the particulars given are to the best of my knowledge true and correct.

Dr's Name : DR Amaizah

Stamp :

Dr. Amaizah Ishtiaq
General Practitioner
DHA: 98486553-001
CITICARE MEDICAL CENTER
DUBAI - U.A.E

Signature :



Date : 28-Jan-2025

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.

Patient 's signature{Parent if minor} :

Date : 28-Jan-2025