Administrative **MEDICAL CLAIM FORM** **Claim Ref:**

Patient Name	: **MANJUSHA ADLAKHA NARAYAN LAL ADLAKHA**	**Service Date:07-Feb-2025**	**Network** : Green
Card No	: **R6604522**	**Health Provider**	**:CITICARE MEDICAL CENTER LLC** **Direct Access SP - YES**
Policy Holder	: **MANJUSHA ADLAKHA NARAYAN LAL ADLAKHA**	**Doctor's Name**	**:Humaira**
Payer Name	: **TAKAFUL EMARAT**	**Co-Insurance**	:
TPA	: **E CARE - Blue Network**	**Remarks**	:
Validity	: **31-07-2024** To **30-07-2025**		
Gender	: **Female**		
Date Of Birth	: **17-Oct-1979**		
Patient's Tel No	: **0523668349**		

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 : 36.6 Bp :130 Pulse :80 Resp :18

Clinical Findings:

Diagnosis: **Date of Onset** : 07/44/2025

Requested Investigations: 9, Consultation GP **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

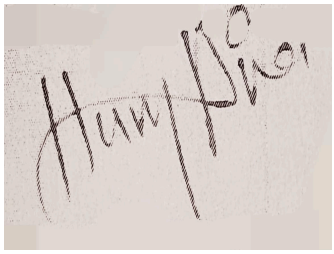
Stamp :

Dr. Humaira Mumtaz
General Practitioner
DHA No: 54155530-002
CITICARE MEDICAL CENTER LLC
DUBAI - U.A.E.

Patient 's signature{Parent : if minor}

Date : 07-Feb-2025

Signature :



Date : 07-Feb-2025