Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	: **ISLAM MAKRAM KAMEL MOUSTAFA**	**Service Date**	:**21-Mar-2025** **Network** : Green
Card No	: **I022-029-121363635-01**	**Health Provider**	:**CITICARE MEDICAL CENTER LLC** **Direct Access SP - YES**
Policy Holder	: **ISLAM MAKRAM KAMEL MOUSTAFA**	**Doctor's Name**	:**DR Amaizah**
Payer Name	: **TAKAFUL EMARAT**	**Co-Insurance**	:
TPA	: **E CARE - Blue Network**	**Remarks**	:
Validity	: **17-09-2024** To **16-09-2025**		
Gender	: **Male**		
Date Of Birth	: **12-Jul-1988**		
Patient's Tel No	: **0524126872**		

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 : pc : sorethroat , bodypain , lethargic , headache started 20/03/25 associated with high grade fever strated 21/03/25 o/e : look lethargic , pale hyperemic pharynx chest wheezing **Duration:**

Vitals: Temp : 38.2 Bp :110 Pulse :106 Resp :18

Clinical Findings:

Diagnosis: J02.9 - Acute pharyngitis, unspecified,R50.9 - Fever, unspecified,R52 - Pain, unspecified, **Date of Onset** :21/46/2025

Requested Investigations: 0195-107704-0802, CEFTRIAXONE-TABUK IM,2190-106618-1001, PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION,0005-111805-1021, CHLOROHISTOL 10MG,96372, THER/PROPH/DIAG INJ SC/IM,85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,86140, C REACTIVE PROTEIN,94640, AIRWAY INHALATION TREATMENT,0006-402803-2071, VENTOLIN NEBULES,96365, THER/PROPH/DIAG IV INF INIT,9, Consultation GP **Estimated Cost** :

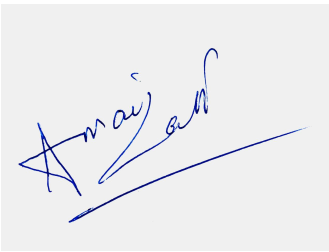
Prescriptions: **Estimated Cost** :

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.

Dr's Name : DR Amaizah **Stamp :**

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

Signature :  **Date** : 21-Mar-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 :** 21-Mar-2025