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

Patient Name	: **ISLAM MAKRAM KAMEL MOUSTAFA**	**Service Date**	:**22-Mar-2025**
Card No	: **I022-029-121363635-01**	**Health Provider**	:**CITICARE MEDICAL CENTER LLC**
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**		

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:

Clinical Findings:

Diagnosis: J02.9 - Acute pharyngitis, unspecified,R50.9 - Fever, unspecified,R52 - Pain, unspecified,J30.9 - Allergic rhinitis, unspecified, **Date of Onset** :22/04/2025

Requested Investigations: 9.01, Follow Up Consultation GP,96372, THER/PROPH/DIAG INJ SC/IM,0195-107704-0802, CEFTRIAXONE-TABUK IM **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 : DR Amaizah

Stamp :

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

Patient 's signature{Parent : if minor}

Date : 22-Mar-2025

Signature :

Date : 22-Mar-2025