Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	: **ISLAM MAKRAM KAMEL MOUSTAFA**	**Service Date**	:**27-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**	:**Humaira**
Payer Name	: **TAKAFUL EMARAT**		
TPA	: **E CARE - Blue Network**		
Validity	: **17-09-2024** To **16-09-2025**	**Remarks**	:
Gender	: **Male**		
Date Of Birth	: **12-Jul-1988**		
Patient's Tel No	: **0524126872**		

Co-Insurance :

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 : high grade fever cold headache weakness flu little bit came 4 days ago and still have fever CRP is high in previous reports **Duration:**

Vitals: Temp : 39 Bp :118 Pulse :113 Resp :0

Clinical Findings:

Diagnosis: J06.9 - Acute upper respiratory infection, unspecified,R50.9 - Fever, unspecified,R05 - Cough,R53.1 - Weakness, **Date of Onset** :27/01/2025

Requested Investigations: 2190-106618-1001, PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION,0102-152902-1001, LACTATED RINGERS INJECTION USP,0195-107704-0801, CEFTRIAXONE-TABUK IV,96365, THER/PROPH/DIAG IV INF INIT,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE,96360, HYDRATION IV INFUSION INIT,96374, THER/PROPH/DIAG INJ IV PUSH,96372, THER/PROPH/DIAG INJ SC/IM,9.01, Follow Up Consultation GP **Estimated Cost** :

Prescriptions: 0031-149904-1171 - (DICLOFENAC SODIUM : 50 MG) TABLETS,0097-127402-0391 - (AZITHROMYCIN : 250 MG) FILM COATED TABLETS,0006-106601-0392 - (PARACETAMOL : 500 MG) FILM COATED TABLETS,0320-148701-1171 - (LORATADINE : 10 MG) TABLETS,0207-169703-1161 - (AMMONIUM CHLORIDE : N/A) (DIPHENHYDRAMINE : N/A) SYRUP, **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.

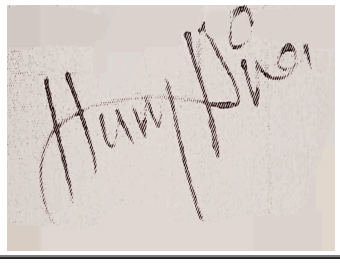
PATIENT'S DECLARATION :

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** : 27-Mar-2025

Signature :  **Date** : 27-Mar-2025