Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	: **MUHAMMAD IRFAN MUHAMMAD ZAMEER**	**Service Date:**	**31-Mar-2025** **Network** : Green
Card No	: **I022-029-119647410-01**	**Health Provider**	**:CITICARE MEDICAL CENTER LLC** **Direct Access SP - YES**
Policy Holder	: **MUHAMMAD IRFAN MUHAMMAD ZAMEER**	**Doctor's Name**	**:Humaira**
Payer Name	: **TAKAFUL EMARAT**	**Co-Insurance**	:
TPA	: **E CARE - Blue Network**	**Remarks**	:
Validity	: **19-09-2024** To **18-09-2025**		
Gender	: **Male**		
Date Of Birth	: **02-Jul-1988**		
Patient's Tel No	: **0558209860**		

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 : dryness in feet itching skin getting remove pain in foot previous history of triglyceridemia **Duration:**

Vitals: Temp : 36.7 Bp :128 Pulse :98 Resp :18

Clinical Findings:

Diagnosis: E78.1 - Pure hyperglyceridemia,B35.3 - Tinea pedis, **Date of Onset** : 31/23/2025

Requested Investigations: 80061, LIPID PANEL,9.01, Follow Up Consultation GP **Estimated Cost** :

Prescriptions: 0186-140201-1451 - (FLUCONAZOLE : 150 MG) CAPSULES (HARD GELATIN),0027-109206-0151 - (TERBINAFINE (AS HCL : 1% CREAM, **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.

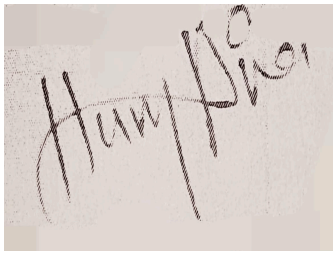
PATIENT'S DECLARATION :

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** : 31-Mar-2025

Signature :  **Date** : 31-Mar-2025