Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	**: JOSHUA LUKE SIMPSON**	**Service Date**	**:05-Apr-2025** **Network** : Green
Card No	**: I022-029-115092346-01**	**Health Provider**	**:CITICARE MEDICAL CENTER LLC** **Direct Access SP - YES**
Policy Holder	**: JOSHUA LUKE SIMPSON**	**Doctor's Name**	**:DR Amaizah**
Payer Name	**: TAKAFUL EMARAT**		
TPA	**: E CARE - Blue Network**	**Co-Insurance**	:
Validity	**: 08-03-2025** To **07-03-2026**		
Gender	**: Male**	**Remarks**	:
Date Of Birth	**: 22-Jun-2012**		
Patient's Tel No	**: 0555722869**		

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 ; SKIN LESIONS AND CRUSTY LESIONS , ASSOCIATED WITH ITCHING EXCESSIVE O/E : RASH , ERYTHMATPOS LESION AND SCALE OF SKIN **Duration:**

Vitals: Temp : 36.5 Bp :86 Pulse :75 Resp :0

Clinical Findings:

Diagnosis: R21 - Rash and other nonspecific skin eruption,R50.9 - Fever, unspecified,L20.9 - Atopic dermatitis, unspecified, **Date of Onset** :05/15/2025

Requested Investigations: 85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,86140, C REACTIVE PROTEIN,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE,0005-111805-1021, CHLOROHISTOL 10MG,96372, THER/PROPH/DIAG INJ SC/IM,82785, Gammaglobulin (immunoglobulin); IgE,11101, Biopsy of skin, subcutaneous tissue and/or mucous membrane (including simple closure), unless otherwise listed; each separate/additional lesion (List separately in addition to code for primary procedure),86160, Complement; antigen, each component,9, Consultation GP,80076, LIVER FUNCTION TEST, MINI,2, BASIC WELLNESS PANEL **Estimated Cost** :

Prescriptions: 0281-367801-0432 - (CALCIPOTRIOL : 50 MCG/G) (BETAMETHASONE (AS DIPROPIONATE) : 0.5 MG/G) GEL,0006-126003-0652 - (FLUTICASONE : 0.05MG/G) OINTMENT,0195-123701-0391 - (CETIRIZINE HCL : 10 MG) FILM COATED TABLETS,0005-119805-1172 - (PREDNISOLONE : 5 MG) TABLETS, **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** : 05-Apr-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 :** 05-Apr-2025