

Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name : JOSHUA LUKE SIMPSON

Card No : I022-029-115092346-01

Policy Holder : JOSHUA LUKE SIMPSON

Payer Name : TAKAFUL EMARAT

TPA : E CARE - Blue Network

Validity : 08-03-2025 To 07-03-2026

Gender : Male

Date Of Birth : 22-Jun-2012

Patient's Tel No : 0555722869

Service Date :05-Apr-2025

Health Provider :CITICARE MEDICAL CENTER LLC

Doctor's Name :DR Amaizah

Co-Insurance :

Remarks :

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 : PC ; SKIN LESIONS AND CRUSTY LESIONS , ASSOCIATED WITH ITCHING

Duration:

EXCESSIVE O/E : RASH , ERYTHMATPOS LESION AND SCALE OF SKIN

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.

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

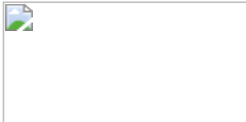
General Practitioner

DHA: 98486553-001

CITICARE MEDICAL CENTER

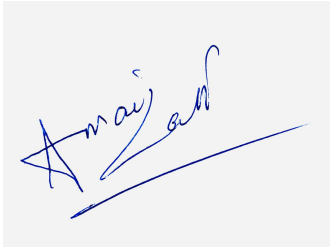
DUBAI - U.A.E

Patient 's signature{Parent : if minor}



05-Apr-2025

Signature :



Date : 05-Apr-2025