Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	: **SYEDA FIRDOS FATIMA SYED**	**Service Date**	:**11-Apr-2025**
Card No	: **784-1999-5264201-7**	**Health Provider**	:**CITICARE MEDICAL CENTER LLC**
Policy Holder	: **SYEDA FIRDOS FATIMA SYED**	**Doctor's Name**	:**DR Amaizah**
Payer Name	: **TAKAFUL EMARAT**	**Co-Insurance**	:
TPA	: **E CARE - Green Network**	**Remarks**	:
Validity	: **31-12-2024** To **30-12-2025**		
Gender	: **Female**		
Date Of Birth	: **30-Jun-1999**		
Patient's Tel No	: **0542998191**		

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 : diharea , vomittig, and bod pain . fever after eating from outside hx of anxiety **Duration:**

Vitals: Temp : 37.1 Bp :107 Pulse :97 Resp :0

Clinical Findings:

Diagnosis: K29.00 - Acute gastritis without bleeding,R11.2 - Nausea with vomiting, unspecified,E86.0 - Dehydration, **Date of Onset** :11/48/2025

Requested Investigations: 0384-207801-1002, LACTATED RINGERS & DEXTROSE USP (CALCIUM CHLORIDE : N/A) (DEXTROSE : N/A) (POTASSIUM CHLORIDE : N/A) (SODIUM CHLORIDE : N/A) (SODIUM LACTATE : N/A) SOLUTION FOR INFUSION SOLUTION FOR INFUSION (500ML, BOTTLE),96360, HYDRATION IV INFUSION INIT,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE,0005-150403-1021, PREMOSAN -(METOCLOPRAMIDE : 10 MG/2ML) SOLUTION FOR INJECTION,0005-174202-0781, RISEK 40MG,93000, Electrocardiogram, routine ECG with at least 12 leads; with interpretation and report,9, Consultation GP,96372, THER/PROPH/DIAG INJ SC/IM,96374, THER/PROPH/DIAG INJ IV PUSH **Estimated Cost** :

Prescriptions:

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** : 11-Apr-2025

Signature : **Date** : 11-Apr-2025