Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	: **ZORAIDA CARDONA CARDONA**	**Service Date**	:**16-Apr-2025**
Card No	: **784-1990-8524381-6**	**Health Provider**	:**CITICARE MEDICAL CENTER LLC**
Policy Holder	: **ZORAIDA CARDONA CARDONA**	**Doctor's Name**	:**Dr.Farhan Iyas**
Payer Name	: **TAKAFUL EMARAT**	**Co-Insurance**	:
TPA	: **E CARE - Blue Network**	**Remarks**	:
Validity	: **28-02-2025** To **27-02-2026**		
Gender	: **Female**		
Date Of Birth	: **19-May-1990**		
Patient's Tel No	: **0561790894**		

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 : history of anal bleeding 2 days back and now she have anal pain no itching but always there is pain sensation low back pain started from yesterday. o/e there is pain in right umbilical region and right side of abdomen pain and tenderness **Duration:**

Vitals: Temp : 36.8 Bp :120 Pulse :78 Resp :18

Clinical Findings:

Diagnosis: K64.9 - Unspecified hemorrhoids,R10.9 - Unspecified abdominal pain,R52 - Pain, unspecified, **Date of Onset :**16/50/2025

Requested Investigations: 0005-136504-1021, SCOPINAL,96372, THER/PROPH/DIAG INJ SC/IM,85027, BLOOD COUNT COMPLETE AUTOMATED,86140, C REACTIVE PROTEIN,9, Consultation GP **Estimated Cost** :

Prescriptions: 0097-142201-0391 - (DICLOFENAC POTASSIUM : 50 MG) FILM COATED TABLETS,1732-531903-0652 - (ALLANTOIN : 0.5% W/W) (LIDOCAINE HCL : 0.5% W/W) OINTMENT,0005-136501-0393 - (HYOSCINE : 10 MG) FILM COATED TABLETS,4884-622202-1171 - (SERRAPEPTASE : 10 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.Farhan Iyas

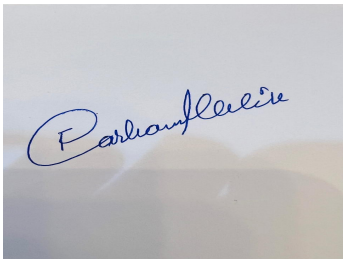
Stamp :

Dr .Frahan Ilyas Malik
Physician-General Practitioner
DHA-06441782-001
CITICARE MEDICAL CENTER
DUBAI U.A.E

Patient 's signature{Parent if minor} :

Date : 16-Apr-2025

Signature :



Date : 16-Apr-2025