Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	: **MUHAMMAD BAHIR**	**Service Date**	:**29-Apr-2025**
Card No	: **I022-029-114042580-01**	**Health Provider**	:**CITICARE MEDICAL CENTER LLC**
Policy Holder	: **MUHAMMAD BAHIR**	**Doctor's Name**	:**AISHA**
Payer Name	: **TAKAFUL EMARAT**		
TPA	: **E CARE - Blue Network**		
Validity	: **30-08-2024** To **29-08-2025**		
Gender	: **Male**		
Date Of Birth	: **16-Jun-1990**		
Patient's Tel No	: **765697144**		

Network : Green

Direct Access SP - YES

Co-Insurance :

CONSULTATION	LAB/RADIOLOGY	PHYSIO	PHARMACY	IP	MATERNITY	DENTAL
10% max	NIL	NIL	NIL LIMIT	NIL	10%	NA

Remarks :

☐ **Acute** ☐ **Pre-existing and chronic** ☐ **Maternity**

Chief Complaints : PC: Pain in throat, cough and headache with body pains,. also having runny nose . with fever 37. Duration: 2days O/E : LOOK LETHARGIC , FEBRILE HYPEREMIC PHARYNX CHEST SLIGHTLY CONGESTED **Duration:**

Vitals: Temp : 37.4 Bp :140 Pulse :92 Resp :18

Clinical Findings:

Diagnosis: J21.9 - Acute bronchiolitis, unspecified,R50.9 - Fever, unspecified,J30.9 - Allergic rhinitis, unspecified,R05 - Cough,R06.2 - Wheezing,K29.00 - Acute gastritis without bleeding,R52 - Pain, unspecified, **Date of Onset** :29/32/2025

Requested Investigations: 9, Consultation GP,96372, THER/PROPH/DIAG INJ SC/IM,0005-111805-1021, CHLOROHISTOL 10MG,2190-106618-1001, PARAFUSIV,96365, THER/PROPH/DIAG IV INF INIT **Estimated Cost** :

Prescriptions: 0397-116207-0391 - (AMOXICILLIN : 500 MG) (CLAVULANIC ACID : 125 MG) FILM COATED TABLETS,0195-123701-0391 - (CETIRIZINE HCL : 10 MG) FILM COATED TABLETS,0005-116801-1161 - (SODIUM CITRATE : 57 MG/5ML) (AMMONIUM CHLORIDE : 131.5 MG/5 ML) (MENTHOL : 1.1 MG/5 ML) (DIPHENHYDRAMINE : 13.5 MG/5ML) SYRUP,0533-105101-1972 - (HERBS : N/A) LIQUID FOR SPRAY (NASAL),0005-107101-0051 - (DIPHENHYDRAMINE : 25 MG) (PARACETAMOL : 325 MG) CAPLETS,0188-135906-2441 - (BUDESONIDE : 0.5 MG/ML) SUSPENSION FOR NEBULIZATION, **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 : AISHA

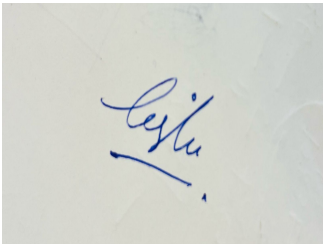
Stamp :

Dr. Aisha Umer
Physician- General Practitioner
DHA- 40131439-002
CITICARE MEDICAL CENTER
DUBAI - U.A.E

Patient 's signature{Parent if minor} :

Date : 29-Apr-2025

Signature :



Date : 29-Apr-2025