Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	**: IKRAM DRICI**	**Service Date**	**:01-May-2025** **Network** : Green
Card No	**: I022-029-122198307-01**	**Health Provider**	**:CITICARE MEDICAL CENTER LLC** **Direct Access SP - YES**
Policy Holder	**: IKRAM DRICI**	**Doctor's Name**	**:Dr.Farhan Iyas**
Payer Name	**: TAKAFUL EMARAT**		
TPA	**: E CARE - Green Network**	**Co-Insurance**	:
Validity	**: 15-04-2025** To **14-04-2026**	**Remarks**	:
Gender	**: Female**		
Date Of Birth	**: 25-Nov-2001**		
Patient's Tel No	**: 0561789075**		

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 : palpitation dizziness dyspnea on exertion pain in neck getting tired so quick history of chronic extrinsic asthma sometimes **Duration:**

Vitals: Temp : 37 Bp :126 Pulse :84 Resp :18

Clinical Findings:

Diagnosis: R25.2 - Cramp and spasm,M25.519 - Pain in unspecified shoulder,R53.1 - Weakness,R00.2 - Palpitations,R42 - Dizziness and giddiness, **Date of Onset** :02/31/2025

Requested Investigations: Pa001, COMPLETE WELLNESS CHECKUP,9, Consultation GP **Estimated Cost :**

Prescriptions: 3819-373201-0391 - (TOLPERISONE HCL : 150 MG) FILM COATED TABLETS,1291-380702-1171 - (BETAHISTINE HCL : 8 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.

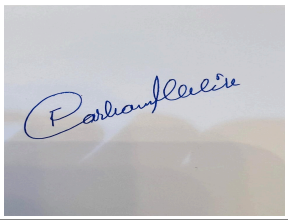
PATIENT'S DECLARATION :

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 :** 02-May-2025

Signature :  **Date** : 02-May-2025