## Administrative MEDICAL CLAIM FORM Claim Ref:

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|---|---|---|---|
| **Patient Name** | **: ALI ISMAIL ABBOUD** | **Service Date** | **:09-May-2025** **Network** : Green |
| **Card No** | **: I022-029-120838063-01** | **Health Provider** | **:CITICARE MEDICAL CENTER LLC** **Direct Access SP - YES** |
| **Policy Holder** | **: ALI ISMAIL ABBOUD** | **Doctor's Name** | **:DR Amaizah** |
| **Payer Name** | **: TAKAFUL EMARAT** | | |
| **TPA** | **: E CARE - Green Network** | **Co-Insurance** | : |
| **Validity** | **: 13-05-2024** To **13-05-2025** | **Remarks** | : |
| **Gender** | **: Male** | | |
| **Date Of Birth** | **: 15-Jan-1989** | | |
| **Patient's Tel No** | **: 0506011301** | | |

| 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 :** 0pc : severe pain in left side of chest in rib cage , which is 08 on pain scale associated with swelling ,and discomfort not able to sit properly pain while beding all happened after fall on ground 07/05/25 took panadol only not improved o/e : rib acge asemtry swelling bruise on left leg **Duration:**

**Vitals:**Temp : 36.6 Bp :126 Pulse :86 Resp :18

**Clinical Findings:**

**Diagnosis:** R07.82 - Intercostal pain,G89.11 - Acute pain due to trauma,R42 - Dizziness and giddiness, **Date of Onset** :09/29/2025

**Requested Investigations:** 0005-149902-1021, CLOFEN -(DICLOFENAC SODIUM : 75 MG/3ML) SOLUTION FOR INJECTION,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE,2190-106618-1001, PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION,96365, THER/PROPH/DIAG IV INF INIT,INJ064, VITAMIN D, INJECTION ,INJ014, INJ-NEUROBION VITAMIN B GROUPS,96372, INJECTION SERVICE-IM,0439-152905-1001, LACTATED RINGERS INJECTION USP,96360, HYDRATION IV INFUSION INIT,96372, THER/PROPH/DIAG INJ SC/IM,9, Consultation GP **Estimated Cost** :

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**Prescriptions:** 0005-119805-1173 - (PREDNISOLONE : 5 MG) TABLETS,

**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 :** 09-May-2025

**Signature :** **Date** : 09-May-2025