Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	: **MUHAMMAD YAHYA HAFIZ**	**Service Date**	:**12-May-2025** **Network** : Green
Card No	: **I022-029-122662800-01**	**Health Provider**	:**CITICARE MEDICAL CENTER LLC** **Direct Access SP - YES**
Policy Holder	: **MUHAMMAD YAHYA HAFIZ**	**Doctor's Name**	:**Dr Bushra**
Payer Name	: **TAKAFUL EMARAT**	**Co-Insurance**	:
TPA	: **E CARE - Blue Network**		
Validity	: **05-05-2025** To **04-05-2026**	**Remarks**	:
Gender	: **Male**		
Date Of Birth	: **14-Jun-2018**		
Patient's Tel No	: **+971 52 520 1204**		

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 : recurrent cough at bed time, attack continues for about an hour - 2 weeks metallic toy balls ingested, autistic, complains of abdominal pain on exam: CNS: gcs 15/15 CVS:S1+S2+0 Chest: wheezy chest, bilateral air entry: equal Abdomen: soft, non tender Throat: enlarged hyperemic tonsils **Duration:**

Vitals: Temp : 36.1 Bp :0 Pulse :100 Resp :24

Clinical Findings:

Diagnosis: J45.991 - Cough variant asthma,T18.2XXA - Foreign body in stomach, initial encounter,J45.20 - Mild intermittent asthma, uncomplicated, **Date of Onset** :12/51/2025

Estimated Cost :

Requested Investigations: 9, Consultation GP,74019, X-RAY EXAM ABDOMEN 2 VIEWS

Prescriptions: 6396-925801-3851 - (SEA WATER (SODIUM CHLORIDE) : 0.9% (28 ML / 100 ML)) NASAL SPRAY,0005-125401-2071 - (IPRATROPIUM BROMIDE : 500MCG/2ML) NEBULIZING SOLUTION,8033-402808-2071 - (SALBUTAMOL(AS SULPHATE) : 2.5 MG/2.5ML) NEBULIZING SOLUTION,0005-662702-0991 - (PREDNISOLONE (SODIUM PHOSPHATE) : 15MG/5ML) SOLUTION,0006-124507-1392 - (SALBUTAMOL : 100 MCG) AEROSOL INHALER, **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 Bushra **Stamp :**

Dr. Bushra Mufti
General practitioner
DHA: 75646242-001
CITICARE MEDICAL CENTER
DUBAI - U.A.E

Patient 's signature{Parent if minor} :  **Date** : 12-May-2025

Signature :  **Date** : 12-May-2025