Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	: **MUHAMMAD ABDUL MOMIN HAFIZ ZAIN**	**Service Date**	: **12-May-2025** **Network** : Green
Card No	: **I022-029-120598979-01**	**Health Provider**	: **CITICARE MEDICAL CENTER LLC** **Direct Access SP - YES**
Policy Holder	: **MUHAMMAD ABDUL MOMIN HAFIZ ZAIN**	**Doctor's Name**	: **Dr Bushra**
Payer Name	: **TAKAFUL EMARAT**	**Co-Insurance**	:
TPA	: **E CARE - Blue Network**	**Remarks**	:
Validity	: **05-05-2025** To **04-05-2026**		
Gender	: **Male**		
Date Of Birth	: **18-May-2022**		
Patient's Tel No	: **0525201204**		

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 : known asthma. now persistent cough attacks at night time does not eat anything 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 :110 Resp :18

Clinical Findings:

Diagnosis: J45.40 - Moderate persistent asthma, uncomplicated,D50.9 - Iron deficiency anemia, unspecified, **Date of Onset :**12/52/2025

Estimated Cost :

Requested Investigations: 9, Consultation GP

Prescriptions: 0006-402803-2071 - (SALBUTAMOL(AS SULPHATE) : 1 MG/ML) NEBULIZING SOLUTION,0005-125402-2071 - (IPRATROPIUM : 250 MCG/ML) NEBULIZING SOLUTION,6396-925801-3851 - (SEA WATER (SODIUM CHLORIDE) : 0.9% (28 ML / 100 ML)) NASAL SPRAY,0005-662702-0991 - (PREDNISOLONE (SODIUM PHOSPHATE) : 15MG/5ML) SOLUTION,0006-124507-1392 - (SALBUTAMOL : 100 MCG) AEROSOL INHALER, **Estimated Cost :**

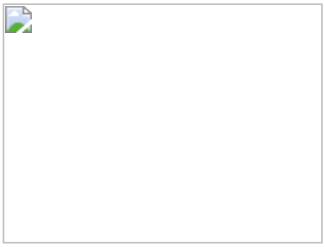
MEDICAL PRACTITIONER DECLARATION :

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.

Dr's Name : Dr Bushra

Stamp :

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

Signature : 

Date : 12-May-2025

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.

Patient 's signature{Parent if minor} : 

Date : 12-May-2025