Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	: **ALEXANDER WILLIAM JOHN LAWRENCE**	**Service Date**	:**13-May-2025** **Network** : Green
Card No	: **I022-029-114302150-01**	**Health Provider**	:**CITICARE MEDICAL CENTER LLC** **Direct Access SP - YES**
Policy Holder	: **ALEXANDER WILLIAM JOHN LAWRENCE**	**Doctor's Name**	:**Dr.Farhan Iyas**
Payer Name	: **TAKAFUL EMARAT**	**Co-Insurance**	:
TPA	: **E CARE - Blue Network**		
Validity	: **10-03-2025** To **09-03-2026**	**Remarks**	:
Gender	: **Male**		
Date Of Birth	: **01-Jan-1978**		
Patient's Tel No	: **554248922**		

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 : pain in the left hypochondrium since about 2 weeks not radiating duration is **Duration:**
10-15 minutes mostly on auscultation there is tenderness in left hypochondrium

Vitals: Temp : 36.8 Bp :120 Pulse :78 Resp :18

Clinical Findings:

Diagnosis: R10.812 - Left upper quadrant abdominal tenderness,R25.2 - Cramp and spasm, **Date of Onset** :13/57/2025

Estimated Cost :

Requested Investigations: 9, Consultation GP

Prescriptions: 0005-136501-0391 - (HYOSCINE : 10 MG) FILM COATED TABLETS,0135-223401-1171 - (NAPROXEN : 500 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

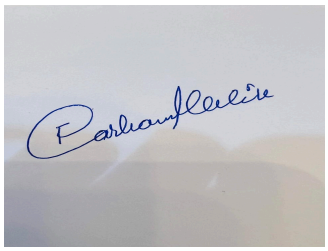
Stamp :

Dr .Frahan Ilyas Malik
Physician-General Practitioner
DHA-06441782-001
CITICARE MEDICAL CENTER
DUBAI U.A.E

Patient 's signature{Parent if minor} :

Date : 13-May-2025

Signature :



Date : 13-May-2025