Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	**: XUEDAN GUO**	**Service Date**	**:05-Jun-2025**
Card No	**: I022-029-114283736-01**	**Health Provider**	**:CITICARE MEDICAL CENTER LLC**
Policy Holder	**: XUEDAN GUO**	**Doctor's Name**	**:AISHA**
Payer Name	**: TAKAFUL EMARAT**		
TPA	**: E CARE - Blue Network**		
Validity	**: 14-06-2024 To 13-06-2025**		
Gender	**: Female**		
Date Of Birth	**: 28-Dec-1989**		
Patient's Tel No	**: 0502186438**		

Network : Green

Direct Access SP - YES

Co-Insurance :

CONSULTATION	LAB/RADIOLOGY	PHYSIO	PHARMACY	IP	MATERNITY	DENTAL
10% max	NIL	NIL	NIL LIMIT	NIL	10%	NA

Remarks :

☐ **Acute** ☐ **Pre-existing and chronic** ☐ **Maternity**

Chief Complaints : pt came with irregular periods for the llast two months . she also complain of weight gain and dizziness **Duration:**

Vitals: Temp : 36.6 Bp :107 Pulse :84 Resp :18

Clinical Findings:

Diagnosis: R73.9 - Hyperglycemia, unspecified,E78.49 - Other hyperlipidemia,E78.00 - Pure hypercholesterolemia, unspecified,E03.9 - Hypothyroidism, unspecified,R30.0 - Dysuria,E79.0 - Hyperuricemia w/o signs of inflam arthrit and tophaceous dis,K76.0 - Fatty (change of) liver, not elsewhere classified,R52 - Pain, unspecified, **Date of Onset** :05/47/2025

Requested Investigations: 80061, LIPID PANEL,80076, HEPATIC FUNCTION PANEL,83036, HEMOGLOBIN GLYCOSYLATED A1C,80069, RENAL FUNCTION PANEL,84443, THYROID STIMULATING HORMONE TSH,84480, TRIIODOTHYRONINE T3 TOTAL TT3,82306, 25 HYDROXY INCLUDES FRACTIONS IF PERFORMED,9, Consultation GP,81007, URINALYSIS BACTERIURIA SCR XCPT CULTURE/DIPSTICK **Estimated Cost :**

Prescriptions: **Estimated Cost :**

MEDICAL PRACTITIONER DECLARATION :

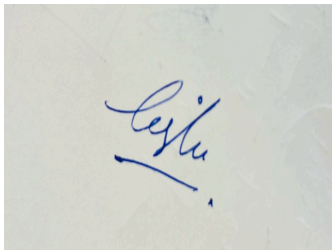
I declare that I am the patient's medical practitioner and that the particulars given are to the best of my knowledge true and correct.

Dr's Name : AISHA

Stamp :

Dr. Aisha Umer
Physician- General Practitioner
DHA- 40131439-002
CITICARE MEDICAL CENTER
DUBAI - U.A.E

Signature :



Date : 05-Jun-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 : 05-Jun-2025