Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	**SYEDA FIRDOS FATIMA SYED**
Card No	**784-1999-5264201-7**
Policy Holder	**SYEDA FIRDOS FATIMA SYED**
Payer Name	**TAKAFUL EMARAT**
TPA	**E CARE - Green Network**
Validity	**31-12-2024** To **30-12-2025**
Gender	**Female**
Date Of Birth	**30-Jun-1999**
Patient's Tel No	**0542998191**

Service Date :**11-Jun-2025** **Network** : Green

Health Provider :**CITICARE MEDICAL CENTER LLC** **Direct Access SP - YES**

Doctor's Name :**DR Amaizah**

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 : P/C : DIZINESS , TREMORS NUMBNESS IN HANDS AND ARMS AND FACE , FEVER STARTED 03/06/25 PREV HX OF UTI and typhoid fever PREVIOUS HX OF STROKE TOOK BLOOD THINNERS PREVIOULY NOW STOPPED hx of epilepsy and seisures post stoke PLT ELEVATED nrrd to start platelets lowering med aspimed LOW HB TLC RAISED **Duration:**

Vitals:

Clinical Findings:

Diagnosis: R03.1 - Nonspecific low blood-pressure reading,R42 - Dizziness and giddiness,R25.1 - Tremor, unspecified,E86.0 - Dehydration,R50.9 - Fever, unspecified,D50.9 - Iron deficiency anemia, unspecified,F41.9 - Anxiety disorder, unspecified,A09 - Infectious gastroenteritis and colitis, unspecified,A01.00 - Typhoid fever, unspecified, **Date of Onset** :11/49/2025

Requested Investigations: 9.01, Follow Up Consultation GP,82947, GLUCOSE QUANTITATIVE BLOOD XCPT REAGENT STRIP,86768, ANTIBODY SALMONELLA,0195-107704-0802, CEFTRIAXONE-TABUK IM,96365, THER/PROPH/DIAG IV INF INIT **Estimated Cost** :

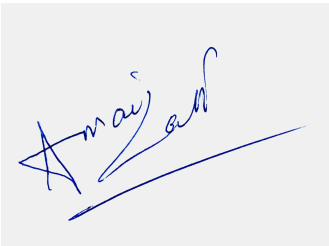
Prescriptions: **Estimated Cost** :

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 : DR Amaizah **Stamp :**

Dr. Amaizah Ishtiaq
General Practitioner
DHA: 98486553-001
CITICARE MEDICAL CENTER
DUBAI - U.A.E

Signature :  **Date** : 11-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 :** 11-Jun-2025