Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	**: VIKTORIE BERANKOVA**	**Service Date**	**:12-Jun-2025**
Card No	**: I022-029-122442373-01**	**Health Provider**	**:CITICARE MEDICAL CENTER LLC**
Policy Holder	**: VIKTORIE BERANKOVA**	**Doctor's Name**	**:AISHA**
Payer Name	**: TAKAFUL EMARAT**		
TPA	**: E CARE - Blue Network**		
Validity	**: 28-03-2025** To **27-03-2026**		
Gender	**: Female**		
Date Of Birth	**: 23-Oct-1997**		
Patient's Tel No	**: 0551879730**		

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 : patient came with skin rash at the edge of right eye ,eight hand and on the chest for 4 days oe irregular margin ,dry and itchy **Duration:**

Vitals: Temp : 36.6 Bp :144 Pulse :70 Resp :18

Clinical Findings:

Diagnosis: B35.4 - Tinea corporis,R21 - Rash and other nonspecific skin eruption,L23.6 - Allergic contact dermatitis due to food in contact w skin, **Date of Onset** :12/08/2025

Requested Investigations: 82785, GAMMAGLOBULIN IGE,0005-111805-1021, CHLOROHISTOL 10MG-(CHLORPHENIRAMINE MALEATE : 10 MG/ML) SOLUTION FOR INJECTION,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE-(DEXAMETHASONE : 4 MG/ML) SOLUTION FOR INJECTION,96372, THER/PROPH/DIAG INJ SC/IM,9, Consultation GP **Estimated Cost** :

Prescriptions: 0005-119805-1172 - (PREDNISOLONE : 5 MG) TABLETS,0195-123701-0391 - (CETIRIZINE HCL : 10 MG) FILM COATED TABLETS,0006-126002-0152 - (FLUTICASONE : 0.5 MG/G) CREAM,0159-140504-2611 - (CLOTRIMAZOLE : 1%) TOPICAL SOLUTION,7048-140201-0061 - (FLUCONAZOLE : 150 MG) CAPSULES, **Estimated Cost** :

MEDICAL PRACTITIONER DECLARATION :

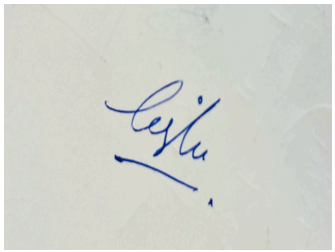
I declare that I am the patient's medical practitioner and that the particulars given are to the best of my knowledge true and correct.

Dr's Name : AISHA

Stamp :

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

Signature :



Date : 12-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 : 12-Jun-2025