Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	**: SANA FAYYAZ ASHFAQ AHMAD SHAHZAD**
Card No	**: I022-029-121571466-01**
Policy Holder	**: SANA FAYYAZ ASHFAQ AHMAD SHAHZAD**
Payer Name	**: TAKAFUL EMARAT**
TPA	**: E CARE - Blue Network**
Validity	**: 26-10-2024** To **25-10-2025**
Gender	**: Female**
Date Of Birth	**: 06-Mar-1983**
Patient's Tel No	**: 0558803738**

Service Date :17-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 : pc : severe headache started just now which is 08 on pian scale associated with nausea and vomitting o/e : look irritable due to pain, pc : pt came with the complain of throat pain hopc :pt came with the complain of severe throat pain since yesterday along with nausea o/e tonsils are hypertrophied chest is clear **Duration:**

Vitals: Temp : 36.8 Bp :120 Pulse :86 Resp :18

Clinical Findings:

Diagnosis: J03.90 - Acute tonsillitis, unspecified,R52 - Pain, unspecified,K29.00 - Acute gastritis without bleeding,R11.0 - Nausea,R51.9 - Headache, unspecified, **Date of Onset** :17/43/2025

Requested Investigations: 9, Consultation GP,0005-149902-1021, CLOFEN ,0248-122107-1021, DEXAMETHASONE SODIUM PHOSPHATE,96372, THER/PROPH/DIAG INJ SC/IM,2190-106618-1001, PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION,96365, THER/PROPH/DIAG IV INF INIT,9, Consultation GP **Estimated Cost** :

Prescriptions: 0397-116207-0391 - (AMOXICILLIN : 500 MG) (CLAVULANIC ACID : 125 MG) FILM COATED TABLETS,0207-533801-1451 - (ESOMEPRAZOLE (AS MAGNESIUM) : 20 MG) CAPSULES (HARD GELATIN),0415-168201-2231 - (DOMPERIDONE : 10 MG) RECTAL SUPPOSITORIES,0097-223401-1171 - (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 Amaizah

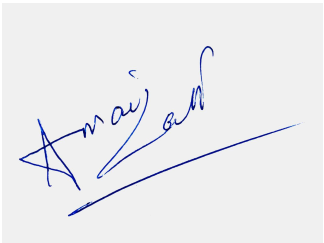
Stamp :

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

Patient 's signature{Parent if minor} :

Date : 17-Jun-2025

Signature :



Date : 17-Jun-2025