

Administrative

MEDICAL CLAIM FORM

Claim Ref:

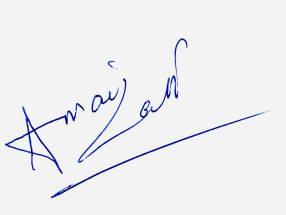
Patient Name : SUHAIL DAR
ABDULRASHID
Card No : I022-029-118290553-01
Policy Holder : SUHAIL DAR
ABDULRASHID
Payer Name : TAKAFUL EMARAT
TPA : ECARE-EBP EBP Enhanced
CLASIC
Validity : 15-02-2025 To 14-02-2026
Gender : Male
Date Of Birth : 23-Feb-1989
Patient's Tel No : 0523268753

Service Date : 19-Jun-2025
Health Provider : CITICARE MEDICAL CENTER LLC
Doctor's Name : DR Amaizah

Network : Green
Direct Access SP - YES

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

Co-Insurance :
Remarks :

☐ Acute	☐ Pre-existing and chronic	☐ Maternity
Chief Complaints : : FEELING STRESSED SHIVERING BLOOD PRESSURE 152/82 BODY PAIN Duration :		
Vitals: Temp : 36.4 Bp :134 Pulse :94 Resp :18		
Clinical Findings:		
Diagnosis: R03.0 - Elevated blood-pressure reading, w/o diagnosis of htn,E78.2 - Mixed hyperlipidemia,R06.02 - Shortness of breath,R00.2 - Palpitations,		Date of Onset :19/59/2025
Requested Investigations: 93000, ELECTROCARDIOGRAM COMPLETE,80051, ELECTROLYTE PANEL,80061, LIPID PANEL,9, Consultation GP		Estimated Cost :
Estimated Cost :		
Prescriptions:		
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 : Jun-2025
Signature : 	Date : 19-Jun-2025	