Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	: **SUHAIL DAR ABDULRASHID**	**Service Date**	:**19-Jun-2025**
Card No	: **I022-029-118290553-01**	**Health Provider**	:**CITICARE MEDICAL CENTER LLC**
Policy Holder	: **SUHAIL DAR ABDULRASHID**	**Doctor's Name**	:**DR Amaizah**
Payer Name	: **TAKAFUL EMARAT**	**Co-Insurance**	:
TPA	: **ECARE-EBP EBP Enhanced CLASIC**	**Remarks**	:
Validity	: **15-02-2025** To **14-02-2026**		
Gender	: **Male**		
Date Of Birth	: **23-Feb-1989**		
Patient's Tel No	: **0523268753**		

Network : Green

Direct Access SP - YES

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

☐ **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** :

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** : 19-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 :** 19-Jun-2025