Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	: **FAHAD SHAHID SHAHID ANWAR**	**Service Date**	:**22-Jun-2025** **Network** : Green
Card No	: **I022-029-114900499-01**	**Health Provider**	:**CITICARE MEDICAL CENTER LLC** **Direct Access SP - YES**
Policy Holder	: **FAHAD SHAHID SHAHID ANWAR**	**Doctor's Name**	:**Dr.Farhan Iyas**
Payer Name	: **TAKAFUL EMARAT**	**Co-Insurance**	:
TPA	: **E CARE - Blue Network**	**Remarks**	:
Validity	: **05-03-2025** To **04-03-2026**		
Gender	: **Male**		
Date Of Birth	: **05-Sep-1980**		
Patient's Tel No	: **0559305315**		

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 : chief complaint: came with dry cough and chest congestion .associated with runny nose and nasal congestion. since one week. 15/06/25. on examination: chest congestion but throat is clear. allergy: no allergy with any medicine previous history: asthma since 15 years back **Duration:**

Vitals: Temp : 36.9 Bp :131 Pulse :90 Resp :22

Clinical Findings:

Diagnosis: J06.9 - Acute upper respiratory infection, unspecified,R05 - Cough,R09.81 - Nasal congestion,R06.7 - Sneezing, **Date of Onset** :22/31/2025

Requested Investigations: 0439-152905-1001, LACTATED RINGERS INJECTION USP,0195-107704-0801, CEFTRIAXONE-TABUK IV,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE,85027, BLOOD COUNT COMPLETE AUTOMATED,86140, C REACTIVE PROTEIN,0188-135906-2441, PULMICORT,96360, HYDRATION IV INFUSION INIT,96372, THER/PROPH/DIAG INJ SC/IM,94640, AIRWAY INHALATION TREATMENT,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,0320-148701-1171 - (LORATADINE : 10 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.

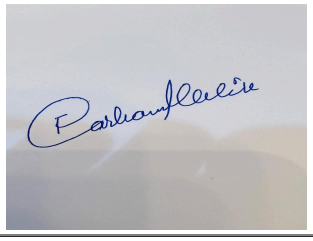
PATIENT'S DECLARATION :

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.Farhan Iyas **Stamp :**

Dr .Frahan Ilyas Malik
Physician-General Practitioner
DHA-06441782-001
CITICARE MEDICAL CENTER
DUBAI U.A.E

Patient 's signature{Parent if minor} : **Date** : 22-Jun-2025

Signature :  **Date** : 22-Jun-2025