Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	**: NILIKA SAMANTHI KODITUWAKKU ARACHCHIGE**	**Service Date**	**:22-Jun-2025** **Network** : Green
Card No	**: I022-029-120409057-01**	**Health Provider**	**:CITICARE MEDICAL CENTER LLC** **Direct Access SP - YES**
Policy Holder	**: NILIKA SAMANTHI KODITUWAKKU ARACHCHIGE**	**Doctor's Name**	**:Dr.Farhan Iyas**
Payer Name	**: TAKAFUL EMARAT**	**Co-Insurance**	:
TPA	**: E CARE - Blue Network**	**Remarks**	:
Validity	**: 01-02-2025** To **31-01-2026**		
Gender	**: Female**		
Date Of Birth	**: 08-Jul-1975**		
Patient's Tel No	**: 0558934908**		

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 : PELVIC PAIN AND LOW BACK PAIN FOR ONE WEEK HOPC PATIENT CAME WITH THE COMPLAIN OF LOWER ABDOMINAL PAIN ALONG WITH BACK PAIN BOTH SIDES FOR THE LAST ONE WEEK . SHE ALSO COMPLAIN OF HAVING DIFFICULTY IN PASSING URINE . O/E HYGASTRIC REGION HAS MILD TENDERNESS NO HISTORY OF CONSTIPATION PERIODS ARE IRREGULAR AND FLOW IS LESS PMH: DIABETES ,CHOLESTEROL,HYPERTENSION . TODAY SHE CAME FOR FOLLOW UP AND REPORT DISCUSSION HBA1C IS 6.7 VITAMIN D IS 14 . **Duration:**

Vitals: Temp : 36.8 Bp :140 Pulse :80 Resp :0

Clinical Findings:

Diagnosis: N39.0 - Urinary tract infection, site not specified,R30.0 - Dysuria,I10 - Essential (primary) hypertension,E55.9 - Vitamin D deficiency, unspecified, **Date of Onset** :22/56/2025

Requested Investigations: INJ064, VITAMIN D, INJECTION ,96372, INJECTION SERVICE-IM,9, Consultation GP **Estimated Cost** :

Prescriptions: 0090-204902-0391 - (SITAGLIPTIN (AS PHOSPHATE) : 50 MG) (METFORMIN HCL : 500 MG) FILM COATED TABLETS,0321-164103-0391 - (METFORMIN HCL : 500 MG) FILM COATED TABLETS,1290-640418-1171 - (VITAMIN D3 (CHOLECALCIFEROL) : 1000 IU) 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.

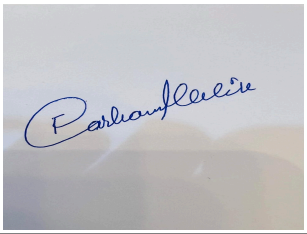
PATIENT'S DECLARATION :

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