Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	: **ASLANBEK AMIEV**	**Service Date**	:**23-Jun-2025**
Card No	: **I022-029-116328439-01**	**Health Provider**	:**CITICARE MEDICAL CENTER LLC**
Policy Holder	: **ASLANBEK AMIEV**	**Doctor's Name**	:**AISHA**
Payer Name	: **TAKAFUL EMARAT**		
TPA	: **E CARE - Green Network**	**Co-Insurance**	:
Validity	: **31-12-2024** To **30-12-2025**	**Remarks**	:
Gender	: **Male**		
Date Of Birth	: **11-Aug-1985**		
Patient's Tel No	: **0505956757**		

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 : pc : high grade fever ,throat pain hopc : pt came with high grade fever ,dizziness along with throat pain and runny nose started two days back .he went to other clinic where he took some medications that was not effective and he has started diarrhea . o/e throat is hyperemic chest is clear dehydration and lethargic allergies : none pmh : none FOLLOW UP HIGH CRP 22 **Duration:**

Vitals: Temp : 37.2 Bp :110 Pulse :88 Resp :18

Clinical Findings:

Diagnosis: J03.90 - Acute tonsillitis, unspecified,K29.00 - Acute gastritis without bleeding, **Date of Onset** :23/15/2025

Requested Investigations: 0195-107704-0801, CEFTRIAXONE-TABUK IV,96374, THER/PROPH/DIAG INJ IV PUSH,0005-174202-0781, RISEK 40MG-(OMEPRAZOLE : 40 MG) POWDER FOR INFUSION,96365, THER/PROPH/DIAG IV INF INIT,9.01, Follow Up Consultation GP **Estimated Cost** :

Prescriptions: **Estimated Cost** :

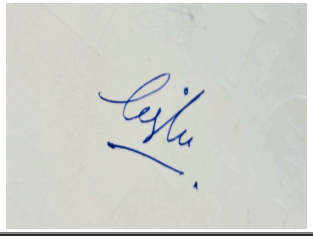
MEDICAL PRACTITIONER DECLARATION :

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 : AISHA

Stamp :

Dr. Aisha Umer
Physician- General Practitioner
DHA- 40131439-002
CITICARE MEDICAL CENTER
DUBAI - U.A.E

Signature : 

Date : 23-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 : 23-Jun-2025