Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	: **FAHAD SHAHID SHAHID ANWAR**	**Service Date**	**:24-Jun-2025**
Card No	: **I022-029-114900499-01**	**Health Provider**	**:CITICARE MEDICAL CENTER LLC**
Policy Holder	: **FAHAD SHAHID SHAHID ANWAR**	**Doctor's Name**	**:AISHA**
Payer Name	: **TAKAFUL EMARAT**		
TPA	: **E CARE - Blue Network**		
Validity	: **05-03-2025** To **04-03-2026**		
Gender	: **Male**		
Date Of Birth	: **05-Sep-1980**		
Patient's Tel No	: **0559305315**		

Network : Green

Direct Access SP - YES

Co-Insurance :

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

Remarks :

☐ **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 follow up chest is congested breathing difficulty crp high 19.2 **Duration:**

Vitals: Temp : 36.9 Bp :131 Pulse :88 Resp :22

Clinical Findings:

Diagnosis: J06.9 - Acute upper respiratory infection, unspecified,J45.991 - Cough variant asthma, **Date of Onset** :24/02/2025

Requested Investigations: 0195-107704-0801, CEFTRIAXONE-TABUK IV,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE-(DEXAMETHASONE : 4 MG/ML) SOLUTION FOR INJECTION,0188-135906-2441, PULMICORT-(BUDESONIDE : 0.5 MG/ML) SUSPENSION FOR NEBULIZATION,96372, THER/PROPH/DIAG INJ SC/IM,96365, THER/PROPH/DIAG IV INF INIT,94640, AIRWAY INHALATION TREATMENT **Estimated Cost** :

Prescriptions: 1393-135904-2441 - (BUDESONIDE : 0.5 MG/2ML) SUSPENSION FOR NEBULIZATION,0005-134003-1161 - (BROMHEXINE HYDROCHLORIDE : 4 MG/5ML) SYRUP,0015-101502-0271 - (ACETYLCYSTEINE : 600 MG) EFFERVESCENT TABLETS,0195-395404-0391 - (MONTELUKAST (AS SODIUM) : 10 MG) FILM COATED 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 : AISHA

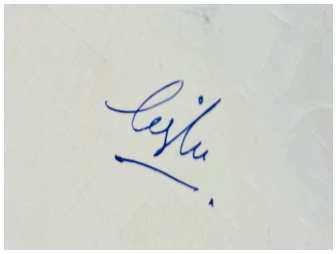
Stamp :

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

Patient 's signature{Parent : if minor}

Date : 24-Jun-2025

Signature :



Date : 24-Jun-2025