Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	: **UMAR KAIROV**	**Service Date**	:**24-Jun-2025**
Card No	: **I022-029-117372778-01**	**Health Provider**	:**CITICARE MEDICAL CENTER LLC**
Policy Holder	: **UMAR KAIROV**	**Doctor's Name**	:**AISHA**
Payer Name	: **TAKAFUL EMARAT**		
TPA	: **E CARE - Green Network**		
Validity	: **31-12-2024** To **30-12-2025**		
Gender	: **Male**		
Date Of Birth	: **21-Jul-1991**		
Patient's Tel No	: **0507942789**		

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 : GENERAL CHECKUP HE HAS OCCASIONAL HIGH BLOOD PRESSURE BUT HE OS **Duration:**
NOT TAKING ANY MEDICATION

Vitals: Temp : 36.8 Bp :130 Pulse :78 Resp :18

Clinical Findings:

Diagnosis: I10 - Essential (primary) hypertension,E78.01 - Familial hypercholesterolemia, **Date of Onset** :24/23/2025

Estimated Cost :

Requested Investigations: 459, BLOOD PACKAGE -459,9, Consultation GP

Estimated Cost :

Prescriptions:

MEDICAL PRACTITIONER DECLARATION :

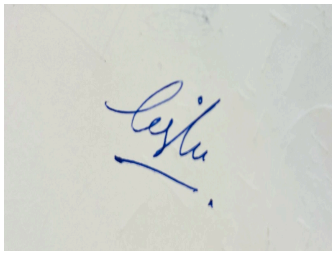
I declare that I am the patient's medical practitioner and that the particulars given are to the best of my knowledge true and correct.

Dr's Name : AISHA

Stamp :

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

Signature :



Date : 24-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 : 24-Jun-2025