Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	: KASSEM CHABAYTA	**Service Date**	:05-Jul-2025 **Network** : Green
Card No	: I022-029-114042578-01	**Health Provider**	:CITICARE MEDICAL CENTER LLC **Direct Access SP - YES**
Policy Holder	: KASSEM CHABAYTA	**Doctor's Name**	:AISHA
Payer Name	: TAKAFUL EMARAT		
TPA	: E CARE - Blue Network	**Co-Insurance**	:
Validity	: 30-08-2024 To 29-08-2025		
Gender	: Male	**Remarks**	:
Date Of Birth	: 16-Nov-1986		
Patient's Tel No	: 0568875264		

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 : with fever 37., PC : THROAT PAIN ,FEVER , COUGH , HOPC : PT CAME WITH THE COMPLAIN OF THROAT PAIN ALONG WITH COUGH AND NASAL CONGESTION STARTED TWO DAYS BACK O/E CHEST IS CONGESTED THROAT IS HYPEREMIC PMH : NONE FEBRILE **Duration:**

Vitals: Temp : 37 Bp :100 Pulse :86 Resp :18

Clinical Findings:

Diagnosis: J02.9 - Acute pharyngitis, unspecified,J30.89 - Other allergic rhinitis,R50.9 - Fever, unspecified,R05 - Cough,R06.2 - Wheezing,K29.00 - Acute gastritis without bleeding,R52 - Pain, unspecified, **Date of Onset** :05/09/2025

Requested Investigations: 9, Consultation GP,96372, THER/PROPH/DIAG INJ SC/IM,0005-149902-1021, CLOFEN **Estimated Cost** :

Prescriptions: 0188-135907-2441 - (BUDESONIDE : 0.25 MG/ML) SUSPENSION FOR NEBULIZATION,0015-101502-0271 - (ACETYLCYSTEINE : 600 MG) EFFERVESCENT TABLETS,0195-123701-0391 - (CETIRIZINE HCL : 10 MG) FILM COATED TABLETS,0397-116207-0391 - (AMOXICILLIN : 500 MG) (CLAVULANIC ACID : 125 MG) FILM COATED TABLETS,0005-134003-1161 - (BROMHEXINE HYDROCHLORIDE : 4 MG/5ML) SYRUP,0207-533801-1451 - (ESOMEPRAZOLE (AS MAGNESIUM) : 20 MG) CAPSULES (HARD GELATIN),5251-624304-3591 - (AZELASTINE HCL : 1 MG/G) (FLUTICASONE PROPIONATE : 0.365 MG/G) SUSPENSION FOR NASAL SPRAY,0005-107001-0051 - (CAFFEINE : 65 MG) (PARACETAMOL : 500 MG) CAPLETS, **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

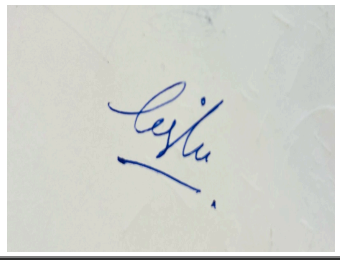
Stamp :

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

Patient 's signature{Parent : if minor}

Date : 05-Jul-2025

Signature :



Date : 05-Jul-2025