Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	: **ISLAM MAKRAM KAMEL MOUSTAFA**	**Service Date**	:**06-Jul-2025** **Network** : Green
Card No	: **I022-029-121363635-01**	**Health Provider**	:**CITICARE MEDICAL CENTER LLC** **Direct Access SP - YES**
Policy Holder	: **ISLAM MAKRAM KAMEL MOUSTAFA**	**Doctor's Name**	:**Dr.Farhan Iyas**
Payer Name	: **TAKAFUL EMARAT**	**Co-Insurance**	:
TPA	: **E CARE - Blue Network**	**Remarks**	:
Validity	: **17-09-2024** To **16-09-2025**		
Gender	: **Male**		
Date Of Birth	: **12-Jul-1988**		
Patient's Tel No	: **0524126872**		

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 : chief complaint: cough with sputum, headache, body ache, nasal congestion.**Duration:**
on examination: chest congestion. allergy: nil previous history: nil

Vitals: Temp : 36.8 Bp :120 Pulse :85 Resp :22

Clinical Findings:

Diagnosis: J06.9 - Acute upper respiratory infection, unspecified,R05 - Cough,R09.81 - Nasal congestion, **Date of Onset :**06/25/2025

Requested Investigations: 0188-135906-2441, PULMICORT,0195-107704-0801, CEFTRIAXONE-TABUK IV,0439-152905-1001, LACTATED RINGERS INJECTION USP,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE,96365, THER/PROPH/DIAG IV INF INIT,85027, BLOOD COUNT COMPLETE AUTOMATED,9, Consultation GP,86140, C REACTIVE PROTEIN,96372, THER/PROPH/DIAG INJ SC/IM,96360, HYDRATION IV INFUSION INIT **Estimated Cost :**

Prescriptions: 7941-044301-3852 - (SODIUM CHLORIDE : 0.9 % W/W) (N-ACETYL CYSTEINE : 1% W/W) (METHYLSULFONYLMETHANE : 1% W/W) NASAL SPRAY,0397-116207-0391 - (AMOXICILLIN : 500 MG) (CLAVULANIC ACID : 125 MG) FILM COATED TABLETS,0320-148701-1171 - (LORATADINE : 10 MG) TABLETS,0027-265802-1161 - (BUTAMIRATE DIHYDROGEN CITRATE : 0.15% W/V) SYRUP, **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

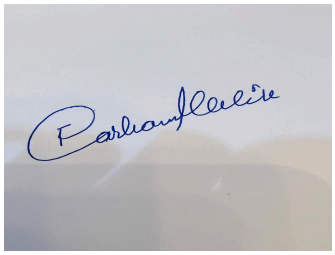
Stamp :

Dr .Frahan Ilyas Malik
Physician-General Practitioner
DHA-06441782-001
CITICARE MEDICAL CENTER
DUBAI U.A.E

Patient 's signature{Parent if minor} :

Date : 06-Jul-2025

Signature :



Date : 06-Jul-2025