Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	**: MOHAMED SALIQ CHANELIPARAMBIL ABDUL KADER**
Card No	**: I022-029-114351406-01**
Policy Holder	**: MOHAMED SALIQ CHANELIPARAMBIL ABDUL KADER**
Payer Name	**: TAKAFUL EMARAT**
TPA	**: E CARE - Blue Network**
Validity	**: 28-03-2025** To **27-03-2026**
Gender	**: Male**
Date Of Birth	**: 23-Jan-1976**
Patient's Tel No	**: 0588878445**

Service Date **:08-Jul-2025** **Network** : Green

Health Provider **:CITICARE MEDICAL CENTER LLC** **Direct Access SP - YES**

Doctor's Name **:AISHA**

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 : follow up : crp high 21.5 high grade fever chest is congested **Duration :**

Vitals: Temp : 39 Bp :149 Pulse :84 Resp :18

Clinical Findings:

Diagnosis: J06.9 - Acute upper respiratory infection, unspecified,R50.9 - Fever, unspecified,E86.0 - Dehydration,R05 - Cough,R52 - Pain, unspecified, **Date of Onset** :08/40/2025

Requested Investigations: 0195-107704-0801, CEFTRIAXONE-TABUK IV,96374, THER/PROPH/DIAG INJ IV PUSH,0188-135906-2441, PULMICORT-(BUDESONIDE : 0.5 MG/ML) SUSPENSION FOR NEBULIZATION,94640, AIRWAY INHALATION TREATMENT,2190-106618-1001, PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION,96360, HYDRATION IV INFUSION INIT,0005-149902-1021, CLOFEN -(DICLOFENAC SODIUM : 75 MG/3ML) SOLUTION FOR INJECTION,96372, THER/PROPH/DIAG INJ SC/IM,0102-100104-1001, SODIUM CHLORIDE & DEXTROSE B.P.,96365, THER/PROPH/DIAG IV INF INIT **Estimated Cost :**

Prescriptions: 0397-116207-0391 - (AMOXICILLIN : 500 MG) (CLAVULANIC ACID : 125 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.

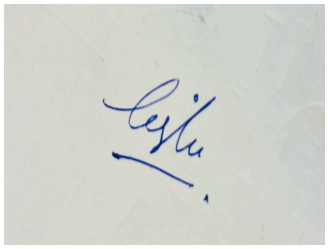
Dr's Name : AISHA

Stamp :

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

Patient 's signature{Parent if minor} :

Date : 08-Jul-2025

Signature : 

Date : 08-Jul-2025