Administrative MEDICAL CLAIM FORM Claim Ref

Patient Name	: **MIKHAIL KARASIK**	**Service Date**	:**14-Jul-2025** **Network** : Green
Card No	: **I022-029-122523549-01**	**Health Provider**	:**CITICARE MEDICAL CENTER LLC** **Direct Access SP**
Policy Holder	: **MIKHAIL KARASIK**	**Doctor's Name**	:**AISHA**
Payer Name	: **TAKAFUL EMARAT**		
TPA	: **E CARE - Green Network**	**Co-Insurance**	:
Validity	: **16-04-2025** To **15-04-2026**	**Remarks**	:
Gender	: **Male**		
Date Of Birth	: **20-Jun-1980**		
Patient's Tel No	: **523742831**		

CONSULTATION	LAB/RADIOLOGY	PHYSIO	PHARMACY	IP	MATEF
10% max	NIL	NIL	NIL LIMIT	NIL	10%

☐ **Acute** ☐ **Pre-existing and chronic** ☐ **Maternity**

Chief Complaints : pc : vertigo , low back pain hopc : pt came with the complain of low back pain along with vertigo started Saturday night . o/e right ear has wax he look pale and uncomfortable allergies : none pmh : none **Duration:**

Vitals: Temp : 36.8 Bp :140 Pulse :84 Resp :18

Clinical Findings:

Diagnosis: H81.319 - Aural vertigo, unspecified ear,R51.9 - Headache, unspecified,R11.0 - Nausea,E86.0 - Dehydration,M54.5 - Low back pain,H61.20 - Impacted cerumen, unspecified ear, **Date of Onset**

Requested Investigations: 2190-106618-1001, PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION,0439-152905-1001, LACTATED RINGERS INJECTION USP,0005-150403-1021, PREMOSAN -(METOCLOPRAMIDE : 10 MG/2ML) SOLUTION FOR INJECTION,96365, THER/PROPH/DIAG IV INF INIT,96360, HYDRATION IV INFUSION INIT,96372, THER/PROPH/DIAG INJ SC/IM,9, Consultation GP,96374, THER/PROPH/DIAG INJ IV PUSH **Estimated Cost** :

Prescriptions: 1217-373201-2401 - (TOLPERISONE : 150 MG) SUGAR COATED TABLETS,2593-163001-0241 - (DOCUSATE : 0.5%) EAR DROPS,1291-380702-1171 - (BETAHISTINE HCL : 8 MG) 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 :

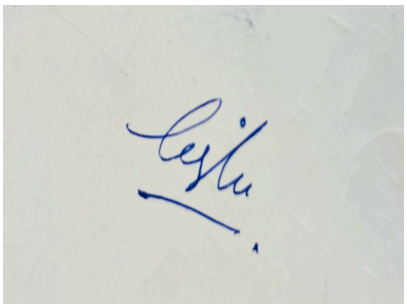
I hereby authorize any Healthca Employer or other organization regarding my medical condition determining insurance benefits.

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} :

Signature : 

Date : 14-Jul-2025