Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	**: MUHAMMAD HASEEB ASHFAQ ASHFAQ AHMAD SHAHZAD**
Card No	**: I022-029-121571465-01**
Policy Holder	**: MUHAMMAD HASEEB ASHFAQ ASHFAQ AHMAD SHAHZAD**
Payer Name	**: TAKAFUL EMARAT**
TPA	**: E CARE - Blue Network**
Validity	**: 26-10-2024** To **25-10-2025**
Gender	**: Male**
Date Of Birth	**: 30-Sep-2008**
Patient's Tel No	**: 0551080254**

Service Date **:16-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 : pc : high grade fever with body pain hopc : pt came with high grade fever along with cough and body pain for the last two days o/e chst is congested throat mild hyperemic **Duration:**

Vitals: Temp : 37.8 Bp :120 Pulse :78 Resp :18

Clinical Findings:

Diagnosis: J02.9 - Acute pharyngitis, unspecified,R50.9 - Fever, unspecified,R05 - Cough,E86.0 - Dehydration,R52 - Pain, unspecified, **Date of Onset** **:**16/07/2025

Requested Investigations: 85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,86140, C REACTIVE PROTEIN,96360, HYDRATION IV INFUSION INIT,96365, THER/PROPH/DIAG IV INF INIT,0439-152905-1001, LACTATED RINGERS INJECTION USP,96360, HYDRATION IV INFUSION INIT,0005-149902-1021, CLOFEN ,96372, THER/PROPH/DIAG INJ SC/IM,9, Consultation GP,2190-106618-1001, PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION **Estimated Cost** :

Prescriptions: 0005-114501-2481 - (AMBROXOL : 15 MG/5ML) SYRUP (SUGAR FREE),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

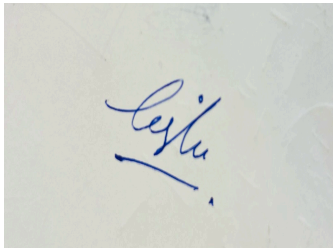
Stamp :

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

Patient 's signature{Parent if minor} :

Date : 16-Jul-2025

Signature :



Date : 16-Jul-2025