

Administrative

MEDICAL CLAIM FORM

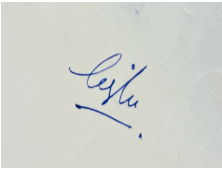
Claim Ref:

Patient Name : MUHAMMAD IRFAN MUHAMMAD ZAMEER
Card No : I022-029-119647410-01
Policy Holder : MUHAMMAD IRFAN MUHAMMAD ZAMEER
Payer Name : TAKAFUL EMARAT
TPA : E CARE - Blue Network
Validity : 19-09-2024 To 18-09-2025
Gender : Male
Date Of Birth : 02-Jul-1988
Patient's Tel No : 0558209860

Service Date:31-Jul-2025
Health Provider :CITICARE MEDICAL CENTER LLC
Doctor's Name :AISHA
Co-Insurance :
Remarks :

Network : Green
Direct Access SP - YES

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 : PC : FEVER , COUGH , BODY PAIN HOPC : PT CAME WITH THE COMPLAIN OF RUNNY NOSE COUGH THROAT PAIN AND FEVER STARTED TWO DAYS BACK O/E THROAT IS CLEAR CHEST IS CONGESTED RHONCHI ALLERGIES : NONE PMC : NONE		
Vitals: Temp : 37.6 Bp :130 Pulse :102 Resp :18		
Clinical Findings:		
Diagnosis: J06.9 - Acute upper respiratory infection, unspecified,R50.9 - Fever, unspecified,R05 - Cough,R06.2 - Wheezing,R52 - Pain, unspecified,J30.9 - Allergic rhinitis, unspecified,E86.0 - Dehydration,		Date of Onset :31/49/2025
Requested Investigations: 85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,86140, C REACTIVE PROTEIN,2190-106618-1001, PARAFUSIV,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE,0005-149902-1021, CLOFEN -(DICLOFENAC SODIUM : 75 MG/3ML) SOLUTION FOR INJECTION,0188-135906-2441, PULMICORT-(BUDESONIDE : 0.5 MG/ML) SUSPENSION FOR NEBULIZATION,0384-111908-1001, SODIUM CHLORIDE B.P.,96372, THER/PROPH/DIAG INJ SC/IM,96365, THER/PROPH/DIAG IV INF INIT,96374, THER/PROPH/DIAG INJ IV PUSH,94640, AIRWAY INHALATION TREATMENT,96360, HYDRATION IV INFUSION INIT,9, Consultation GP		Estimated : Cost
Prescriptions: 0207-142902-1451 - (CEFIXIME : 400 MG) CAPSULES (HARD GELATIN),0320-148701-1171 - (LORATADINE : 10 MG) TABLETS,0005-114501-2481 - (AMBROXOL : 15 MG/5ML) SYRUP (SUGAR FREE),0005-107001-0052 - (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}  31-Jul-2025
Signature : 	Date : 31-Jul-2025	