Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	: **Abdul Nasir Farzand Ali**	**Service Date**	:**03-Aug-2025** **Network** : Green
Card No	: **I022-029-117919277-01**	**Health Provider**	:**CITICARE MEDICAL CENTER LLC** **Direct Access SP - YES**
Policy Holder	: **Abdul Nasir Farzand Ali**	**Doctor's Name**	:**DR Amaizah**
Payer Name	: **TAKAFUL EMARAT**		
TPA	: **E CARE - Green Network**	**Co-Insurance**	:
Validity	: **19-06-2025** To **18-06-2026**	**Remarks**	:
Gender	: **Male**		
Date Of Birth	: **09-May-1990**		
Patient's Tel No	: **0556560403**		

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 : sore throat , bodypain , headache , fever low grade ,and cough which is dry , nasal congestion started 31/07/25 o/e look irritable hyperemic pharynx chest wheezing **Duration:**

Vitals: Temp : 36.6 Bp :100 Pulse :100 Resp :18

Clinical Findings:

Diagnosis: J03.90 - Acute tonsillitis, unspecified,R05 - Cough,J30.9 - Allergic rhinitis, unspecified,R50.9 - Fever, unspecified,R06.2 - Wheezing,M54.5 - Low back pain,R07.0 - Pain in throat, **Date of Onset** :03/10/2025

Requested Investigations: 85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,86140, C REACTIVE PROTEIN,94640, AIRWAY INHALATION TREATMENT,0188-135906-2441, PULMICORT,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE,0005-111805-1021, CHLOROHISTOL 10MG,2190-106618-1001, PARAFUSIV,96372, THER/PROPH/DIAG INJ SC/IM,96365, THER/PROPH/DIAG IV INF INIT,9, Consultation GP **Estimated Cost** :

Prescriptions: 0006-106601-0394 - (PARACETAMOL : 500 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 : DR Amaizah **Stamp :**

Dr. Amaizah Ishtiaq
General Practitioner
DHA: 98486553-001
CITICARE MEDICAL CENTER
DUBAI - U.A.E

Patient 's signature{Parent if minor} : **Date** : 03-Aug-2025

Signature : **Date** : 03-Aug-2025