Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	: **MUHAMMAD IRFAN MUHAMMAD ZAMEER**	**Service Date**	:**05-Aug-2025** **Network** : Green
Card No	: **I022-029-119647410-01**	**Health Provider**	:**CITICARE MEDICAL CENTER LLC** **Direct Access SP - YES**
Policy Holder	: **MUHAMMAD IRFAN MUHAMMAD ZAMEER**	**Doctor's Name**	:**AISHA**
Payer Name	: **TAKAFUL EMARAT**	**Co-Insurance**	:
TPA	: **E CARE - Blue Network**	**Remarks**	:
Validity	: **19-09-2024** To **18-09-2025**		
Gender	: **Male**		
Date Of Birth	: **02-Jul-1988**		
Patient's Tel No	: **0558209860**		

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 : Followup PC : pt presented with complaints of swelling left lower jaw since yesterday night O\e left submandibular non tender swelling and there enlarge lymph node enlargement Advised to continue the medications and to give icewater compress over the area crp is high 40 **Duration:**

Vitals: Temp : 36.4 Bp :110 Pulse :90 Resp :18

Clinical Findings:

Diagnosis: J03.90 - Acute tonsillitis, unspecified,L04.0 - Acute lymphadenitis of face, head and neck,R50.9 - Fever, unspecified,R05 - Cough,E86.0 - Dehydration, **Date of Onset** :05/02/2025

Requested Investigations: 96360, HYDRATION IV INFUSION INIT,96372, THER/PROPH/DIAG INJ SC/IM,96365, THER/PROPH/DIAG IV INF INIT,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE,0005-149902-1021, CLOFEN ,0195-107704-0801, CEFTRIAXONE-TABUK IV,2190-106618-1001, PARAFUSIV,0384-111908-1001, SODIUM CHLORIDE B.P.,96374, THER/PROPH/DIAG INJ IV PUSH **Estimated Cost** :

Prescriptions: 6705-602505-3801 - (HYDROXYPROPYLMETHYLCELLULOSE : 150 MG/ 30ML) SPRAY SOLUTION,0005-119803-1171 - (PREDNISOLONE : 20 MG) TABLETS,0250-125820-3931 - (POVIDONE IODINE : 1%) MOUTHWASH-SOLUTION,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.

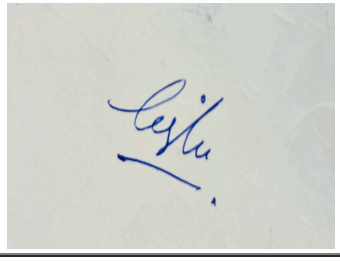
PATIENT'S DECLARATION :

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 :** 05-Aug-2025

Signature :  **Date** : 05-Aug-2025