Administrative **MEDICAL CLAIM FORM** **Claim Ref:**

Patient Name	: **ANJALI RAWTHER MOHAMMED RAFFI**	**Service Date**	:**07-Aug-2025**
Card No	: **I005-029-121476931-01**	**Health Provider**	:**CITICARE MEDICAL CENTER LLC**
Policy Holder	: **ANJALI RAWTHER MOHAMMED RAFFI**	**Doctor's Name**	:**AISHA**
Payer Name	: **DUBAI INSURANCE COMPANY**	**Co-Insurance**	:
TPA	: **E CARE - Blue Network**	**Remarks**	:
Validity	: **02-10-2024** To **01-10-2025**		
Gender	: **Female**		
Date Of Birth	: **28-Aug-1995**		
Patient's Tel No	: **0585886414**		

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: generalize weakness **Duration** :

Vitals: Temp : 36.4 Bp :100 Pulse :80 Resp :18

Clinical Findings:

Diagnosis: R53.1 - Weakness,E86.0 - Dehydration, **Date of Onset** : 07/47/2025

Requested Investigations: 85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,86140, C REACTIVE PROTEIN,97010, SPECIAL SUPPLIES,9, Consultation GP **Estimated Cost** :

Prescriptions: **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

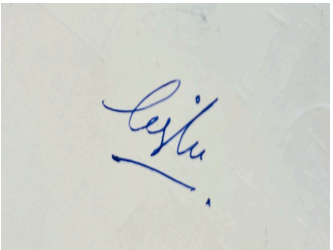
Stamp :

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

Patient 's signature{Parent if minor} :

Date : 07-Aug-2025

Signature :



Date : 07-Aug-2025