Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name : Ramesh Kumar
Card No : I022-029-120467737-01
Policy Holder : Ramesh Kumar
Payer Name : TAKAFUL EMARAT
TPA : E CARE - Green Network
Validity : 19-06-2025 To 18-06-2026
Gender : Male
Date Of Birth : 05-Jan-1997
Patient's Tel No : 0545766439

Service Date :10-Aug-2025 **Network** : Green
Health Provider :CITICARE MEDICAL CENTER LLC **Direct Access SP - YES**
Doctor's Name :DR Amaizah

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 : mouth ulcers and pain and soreness , bodypain , headache , and low garde fever , started 09/08/25 o/e : look pale , lethargic blister ,on tongue and gums **Duration:**

Vitals: Temp : 36 Bp :110 Pulse :80 Resp :18

Clinical Findings:

Diagnosis: K29.00 - Acute gastritis without bleeding,K12.30 - Oral mucositis (ulcerative), unspecified,R21 - Rash and other nonspecific skin eruption,T78.49XA - Other allergy, initial encounter, **Date of Onset** :10/51/2025

Requested Investigations: 85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,82785, GAMMAGLOBULIN IGE,84460, TRANSFERASE ALANINE AMINO ALT SGPT,86140, C REACTIVE PROTEIN,9, Consultation GP **Estimated Cost** :

Prescriptions: 0005-187502-0151 - (BETAMETHASONE : 0.10%) (FUSIDIC ACID : 2%) CREAM,0005-119805-1172 - (PREDNISOLONE : 5 MG) TABLETS,1709-404803-0431 - (BENZOCAINE : 10%) GEL, **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.

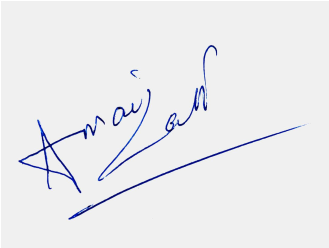
PATIENT'S DECLARATION :

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** : 10-Aug-2025

Signature :  **Date** : 10-Aug-2025