Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	**: Dahiana Arboleda Cardona**
Card No	**: 784-2007-8757108-0**
Policy Holder	**: Dahiana Arboleda Cardona**
Payer Name	**: TAKAFUL EMARAT**
TPA	**: E CARE - Blue Network**
Validity	**: 28-02-2025** To **27-02-2026**
Gender	**: Female**
Date Of Birth	**: 22-Aug-2007**
Patient's Tel No	**: 0561790894**

Service Date **:18-Aug-2025** **Network** : Green

Health Provider **:CITICARE MEDICAL CENTER LLC** **Direct Access SP - YES**

Doctor's Name **:Dr.Farhan Iyas**

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 : chief complaint: came with the pain in the right ear started 3 days ago, on examination: she have white color ear wax in the right ear. **Duration:**

Vitals: Temp : 36.8 Bp :110 Pulse :74 Resp :18

Clinical Findings:

Diagnosis: H61.21 - Impacted cerumen, right ear,H92.01 - Otalgia, right ear, **Date of Onset** :18/26/2025

Estimated Cost :

Requested Investigations: 9, Consultation GP

Prescriptions: 4884-622202-1171 - (SERRAPEPTASE : 10 MG) TABLETS,2593-163001-0241 - (DOCUSATE : 0.5%) EAR DROPS,

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.Farhan Iyas

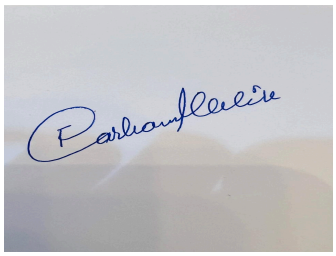
Stamp :

Dr .Frahan Ilyas Malik
Physician-General Practitioner
DHA-06441782-001
CITICARE MEDICAL CENTER
DUBAI U.A.E

Patient 's signature{Parent if minor} :

Date : 18-Aug-2025

Signature :



Date : 18-Aug-2025