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 :**21-Aug-2025** **Network** : Green

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

Doctor's Name :**AISHA**

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 : follow no improvement still she has ear blocked with wax **Duration :**

Vitals: Temp : 37 Bp :110 Pulse :80 Resp :18

Clinical Findings:

Diagnosis: H61.21 - Impacted cerumen, right ear,H92.01 - Otalgia, right ear, **Date of Onset** :21/35/2025

Requested Investigations: 69210, RMVL IMPACTED CERUMEN SPX 1/BOTH EARS **Estimated Cost :**

Prescriptions: 0355-103204-1681 - (CIPROFLOXACIN : 0.3%) EYE / EAR DROPS,0003-281701-0241 - (BENZOCAINE : 1.4%) (TYROTHRICIN : 0.05%) (ANTIPYRINE : 5%) (HEXYLRESORCINOL : 0.10%) 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 : AISHA

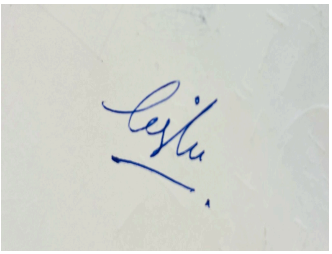
Stamp :

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

Patient 's signature{Parent if minor} :

Date : 21-Aug-2025

Signature :



Date : 21-Aug-2025