Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	: Dahiana Arboleda Cardona	**Service Date**	:22-Oct-2024
Card No	: 784-2007-8757108-0	**Health Provider**	:CITICARE MEDICAL CENTER LLC
Policy Holder	: Dahiana Arboleda Cardona	**Doctor's Name**	:Humaira
Payer Name	: TAKAFUL EMARAT	**Co-Insurance**	:
TPA	: E CARE - Blue Network	**Remarks**	:
Validity	: 29-02-2024 To 27-02-2025		
Gender	: Female		
Date Of Birth	: 22-Aug-2007		
Patient's Tel No	: 0561790894		

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 : **Duration :**

Vitals: Temp : 37.2 Bp :100 Pulse :64 Resp :18

Clinical Findings:

Diagnosis: N39.0 - Urinary tract infection, site not specified,N39.43 - Post-void dribbling,R30.9 - Painful micturition, unspecified,K29.00 - Acute gastritis without bleeding,R73.9 - Hyperglycemia, unspecified, **Date of Onset** :22/28/2024

Requested Investigations: 82947, GLUCOSE QUANTITATIVE BLOOD XCPT REAGENT STRIP,83036, HEMOGLOBIN GLYCOSYLATED A1C,9.01, Follow Up Consultation GP,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 : Humaira

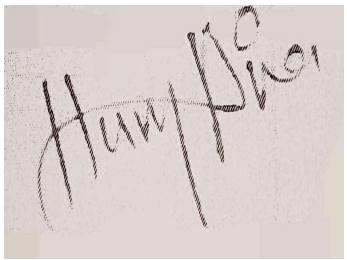
Stamp :

Dr. Humaira Mumtaz
General Practitioner
DHA No: 54155530-002
CITICARE MEDICAL CENTER LLC
DUBAI - U.A.E.

Patient 's signature{Parent if minor} :

Date : 22-Oct-2024

Signature :



Date : 22-Oct-2024