Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	: **MUHAMMAD USMAN KHAN ZAFAR ULLAH**	**Service Date**	:**26-Oct-2024** **Network** : Green
Card No	: **I022-029-121552566-01**	**Health Provider**	:**CITICARE MEDICAL CENTER LLC** **Direct Access SP - YES**
Policy Holder	: **MUHAMMAD USMAN KHAN ZAFAR ULLAH**	**Doctor's Name**	:**AHSAN HUSSAIN**
Payer Name	: **TAKAFUL EMARAT**	**Co-Insurance**	:
TPA	: **E CARE - Blue Network**	**Remarks**	:
Validity	: **23-10-2024** To **22-10-2025**		
Gender	: **Male**		
Date Of Birth	: **30-Mar-1990**		
Patient's Tel No	: **0567617456**		

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: swelling on face and feet dehydration **Duration :**

Vitals: Temp : 37.1 Bp :134 Pulse :90 Resp :18

Clinical Findings:

Diagnosis: E03.9 - Hypothyroidism, unspecified,I10 - Essential (primary) hypertension,R22.43 - Localized swelling, mass and lump, lower limb, bilateral,R07.9 - Chest pain, unspecified, **Date of Onset** :26/09/2024

Requested Investigations: 80069, RENAL FUNCTION PANEL,85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,84443, THYROID STIMULATING HORMONE TSH,9, Consultation GP **Estimated Cost** :

Prescriptions: 1007-124204-0342 - (ASPIRIN : 100 MG) ENTERIC COATED TABLETS, **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 : AHSAN HUSSAIN **Stamp :**

Dr. Ahsan Hussain
General Practitioner
DHA No: 87543658-001
CITICARE MEDICAL CENTER LLC
DUBAI - U.A.E.

Patient 's signature{Parent if minor} : **Date :** 26-Oct-2024

Signature : **Date** : 26-Oct-2024