

Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name : MUHAMMAD USMAN
KHAN ZAFAR ULLAH
Card No : I022-029-121552566-01
Policy Holder : MUHAMMAD USMAN
KHAN ZAFAR ULLAH

Payer Name : TAKAFUL EMARAT

TPA : E CARE - Blue Network

Validity : 23-10-2024 To 22-10-2025

Gender : Male

Date Of Birth : 30-Mar-1990

Patient's Tel No : 0567617456

Service Date:26-Oct-2024

Network : Green

Health Provider :CITICARE MEDICAL CENTER LLC

Direct Access SP - YES

Doctor's Name :AHSAN HUSSAIN

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: 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

Estimated :

AUTO&AUTO DIFRNTL WBC COUNT,84443, THYROID STIMULATING HORMONE TSH,9, Consultation GP

Cost

Estimated Cost :

Prescriptions: 1007-124204-0342 - (ASPIRIN : 100 MG) ENTERIC COATED TABLETS,

MEDICAL PRACTITIONER DECLARATION :

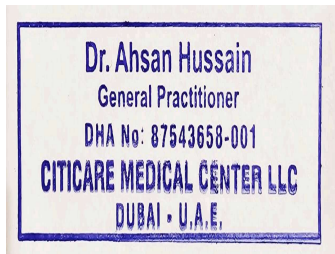
I declare that I am the patient's medical practitioner and that the particulars given are to the best of my knowledge true and correct.

PATIENT'S DECLARATION :

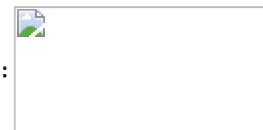
I hereby authorize any Healthcare provider, Insurer, Employer or other organization to release any information regarding my medical condition & history for purpose of determining insurance benefits.

Dr's Name : AHSAN HUSSAIN

Stamp :



Patient's signature{Parent : if minor}



Date : Oct-2024

Signature :

Date : 26-Oct-2024