Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	**: EI THET HTAR KHIN**	**Service Date**	**:12-Aug-2024**	**Network**	**: Green**
Card No	**: I017-029-120176773-01**	**Health Provider**	**:CITICARE MEDICAL CENTER LLC**		**Direct Access SP - YES**
Policy Holder	**: EI THET HTAR KHIN**	**Doctor's Name**	**:Humaira**		
Payer Name	**: ABU DHABI NATIONAL INSURANCE COMPANY-ADNIC**	**Co-Insurance**	:		
TPA	**: E CARE - Green Network**	**Remarks**	:		
Validity	**: 01-01-1900** To **30-09-2024**				
Gender	**: Female**				
Date Of Birth	**: 20-Jun-1999**				
Patient's Tel No	**: 505437451**				

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 : co pain in the lower abdomen today is the first day of mensis weakness pain **Duration:** in throat 8th august 2024 oe chest is clear no added sounds stable

Vitals: Temp : 37.5 Bp :120 Pulse :92 Resp :18

Clinical Findings:

Diagnosis: R10.30 - Lower abdominal pain, unspecified,R53.1 - Weakness,R52 - Pain, unspecified, **Date of Onset :**12/42/2024

Requested Investigations: 0005-149902-1021, CLOFEN -(DICLOFENAC SODIUM : 75 MG/3ML) SOLUTION FOR INJECTION,96372, THER/PROPH/DIAG INJ SC/IM,9, Consultation GP **Estimated Cost :**

Prescriptions: 0250-125820-3931 - (POVIDONE IODINE : 1%) MOUTHWASH-SOLUTION,0027-142201-0831 - (DICLOFENAC POTASSIUM : 50 MG) POWDER FOR SOLUTION,1233-564801-1171 - (PYRIDOXINE (VITAMIN B6) : 2 MG) (VITAMIN B12 : 1 MG) (THIAMINE (VITAMIN B1) : 1.4 MG) (NIACINAMIDE : 18 MG) (BETACAROTENE : 400 MCG) (PHYTONADIONE (VITAMIN K1) : 30 MCG) (VITAMIN E : 10 IU) (BIOTIN : 100 MCG) (CHROMIUM : 40 MCG) (RIBOFLAVINE (VITAMIN B2) : 1.4 MG) (POTASSIUM : 40 MG) (ASCORBIC ACID (VITAMIN C) : 60 MG) (ZINC : 5 MG) (PHOSPHORUS : 125 MG) (SELENIUM : 30 MCG) (MAGNESIUM : 50 MG) (MOLYBDENUM : 50 MCG) 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.

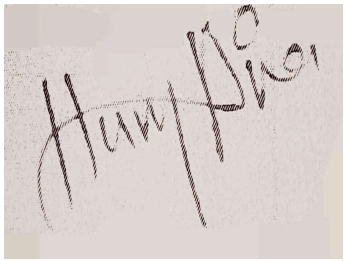
PATIENT'S DECLARATION :

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 : 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 :** 12-Aug-2024

Signature :  **Date** : 12-Aug-2024