Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	: **WAQAR AHMED MOHD ASLAM**	**Service Date**	**:23-Aug-2024**
Card No	: **I017-029-119050823-01**	**Health Provider**	**:CITICARE MEDICAL CENTER LLC**
Policy Holder	: **WAQAR AHMED MOHD ASLAM**	**Doctor's Name**	**:AHSAN HUSSAIN**
Payer Name	: **ABU DHABI NATIONAL INSURANCE COMPANY-ADNIC**	**Co-Insurance**	:
TPA	: **E CARE - Green Network**	**Remarks**	:
Validity	: **01-10-2023** To **30-09-2024**		
Gender	: **Male**		
Date Of Birth	: **15-Jan-1998**		
Patient's Tel No	: **0545734696**		

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 : PC: HEAVY LIFT WEIGHT 1 DAY BACK PAIN LEFT NECK AND SHOULDER WITH SWELLING 1 DAY BACK **Duration:**

Vitals: Temp : 36.3 Bp :105 Pulse :85 Resp :18

Clinical Findings:

Diagnosis: R52 - Pain, unspecified,R22.2 - Localized swelling, mass and lump, trunk, **Date of Onset** :23/50/2024

Requested Investigations: 0005-149902-1021, CLOFEN ,2190-106618-1001, PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION,96365, THER/PROPH/DIAG IV INF INIT,96372, THER/PROPH/DIAG INJ SC/IM,9, Consultation GP **Estimated Cost** :

Prescriptions: 2093-596002-0432 - (DICLOFENAC DIETHYLAMINE : 23.2 MG / G) GEL,4179-711202-0391 - (IBUPROFEN (AS L-ARGININE SALT) : 400 MG) FILM 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.

Dr's Name : AHSAN HUSSAIN **Stamp :**

Signature : **Date** : 23-Aug-2024

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.

Patient 's signature{Parent if minor} : **Date :** 23-Aug-2024