Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	**: SU SU HTWE**	**Service Date**	**:28-Aug-2024**
Card No	**: I017-029-120181224-01**	**Health Provider**	**:CITICARE MEDICAL CENTER LLC**
Policy Holder	**: SU SU HTWE**	**Doctor's Name**	**:Humaira**
Payer Name	**: ABU DHABI NATIONAL INSURANCE COMPANY-ADNIC**	**Co-Insurance**	**:**
TPA	**: E CARE - Blue Network**	**Remarks**	**:**
Validity	**: 11-12-2023** To **10-12-2024**		
Gender	**: Female**		
Date Of Birth	**: 11-May-1975**		
Patient's Tel No	**: 0545797666**		

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 : 38.1 Bp :126 Pulse :112 Resp :18

Clinical Findings:

Diagnosis: N39.0 - Urinary tract infection, site not specified,R10.30 - Lower abdominal pain, unspecified, **Date of Onset :**28/18/2024

Estimated Cost :

Requested Investigations: 9.01, Follow Up Consultation GP

Estimated Cost :

Prescriptions:

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

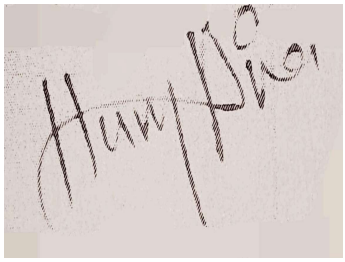
Stamp :

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

Patient 's signature{Parent if minor} :

Date : 28-Aug-2024

Signature :



Date : 28-Aug-2024