

Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name : SOUKAINA EL HARAR

Card No : I017-029-116362606-02

Policy Holder : SOUKAINA EL HARAR

Payer Name : ABU DHABI NATIONAL INSURANCE COMPANY-ADNIC

TPA : E CARE - Green Network

Validity : 01-10-2023 To 30-09-2024

Gender : Female

Date Of Birth : 14-Oct-1998

Patient's Tel No : 0507437356

Service Date :04-Sep-2024

Health Provider :CITICARE MEDICAL CENTER LLC

Doctor's Name :AHSAN HUSSAIN

Co-Insurance :

CONSULTATION	LAB/RADIOLOGY	PHYSIO	PHARMACY	IP	MATERNITY	DENTAL
10% max	NIL	NIL	NIL LIMIT	NIL	10%	NA

Network : Green

Direct Access SP - YES

Remarks :

☐ Acute

☐ Pre-existing and chronic

☐ Maternity

Chief Complaints : svere headache muscle pain

Duration :

Vitals:Temp : 36.9 Bp :116 Pulse :86 Resp :20

Clinical Findings:

Diagnosis: G89.11 - Acute pain due to trauma,M54.5 - Low back pain,

Date of Onset :04/20/2024

Requested Investigations: 0005-149902-1021, CLOFEN ,2190-106618-1001, PARAFUSIV,96365, THER/PROPH/DIAG IV INF INIT,96372, THER/PROPH/DIAG INJ SC/IM,9, Consultation GP

Estimated : Cost

Prescriptions: 4179-711202-0391 - (IBUPROFEN (AS L-ARGININE SALT) : 400 MG) FILM COATED TABLETS,1217-373201-2401 - (TOLPERISONE : 150 MG) SUGAR 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 :

Dr. Ahsan Hussain

General Practitioner

DHA No: 87543658-001

CITICARE MEDICAL CENTER LLC

DUBAI - U.A.E,

Signature :

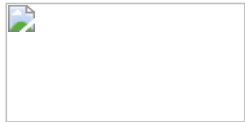


Date : 04-Sep-2024

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 : Sep-2024