Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	**: SOUKAINA EL HARAR**	**Service Date**	**:04-Sep-2024**
Card No	**: I017-029-116362606-02**	**Health Provider**	**:CITICARE MEDICAL CENTER LLC**
Policy Holder	**: SOUKAINA EL HARAR**	**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	**: Female**		
Date Of Birth	**: 14-Oct-1998**		
Patient's Tel No	**: 0507437356**		

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 : 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.

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 :**

Dr. Ahsan Hussain
General Practitioner
DHA No: 87543658-001
CITICARE MEDICAL CENTER LLC
DUBAI - U.A.E.

Patient 's signature{Parent if minor} :

Date : 04-Sep-2024

Signature :

Date : 04-Sep-2024