Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	: **JULIE ROSE SUMANG FLORES**	**Service Date**	**:08-Oct-2024**
Card No	: **I017-029-120820677-01**	**Health Provider**	**:CITICARE MEDICAL CENTER LLC**
Policy Holder	: **JULIE ROSE SUMANG FLORES**	**Doctor's Name**	**:Humaira**
Payer Name	: **ABU DHABI NATIONAL INSURANCE COMPANY-ADNIC**	**Co-Insurance**	:
TPA	: **E CARE - Blue Network**	**Remarks**	:
Validity	: **21-05-2024** To **22-05-2025**		
Gender	: **Female**		
Date Of Birth	: **07-Oct-1979**		
Patient's Tel No	: **0502402893**		

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 : she was working in the office got injured from the door left arm is affacted 7th oct. 2024 co pain inthe left arm oe redness around the elbow joint chest is clear no added sounds restless **Duration:**

Vitals: Temp : 36.6 Bp :120 Pulse :80 Resp :18

Clinical Findings:

Diagnosis: S59.909A - Unspecified injury of unspecified elbow, initial encounter,M25.522 - Pain in left elbow, **Date of Onset :**08/51/2024

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: 2093-596002-0432 - (DICLOFENAC DIETHYLAMINE : 23.2 MG / G) GEL,0027-142201-0832 - (DICLOFENAC POTASSIUM : 50 MG) POWDER FOR SOLUTION, **Estimated Cost** :

MEDICAL PRACTITIONER DECLARATION :

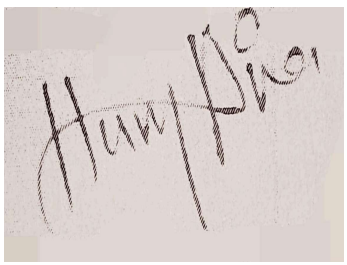
I declare that I am the patient's medical practitioner and that the particulars given are to the best of my knowledge true and correct.

Dr's Name : Humaira

Stamp :

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

Signature :



Date : 08-Oct-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 : 08-Oct-2024