Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	**: MANJUSHA ADLAKHA NARAYAN LAL ADLAKHA**	**Service Date:**	**15-Oct-2024**
Card No	**: R6604522**	**Health Provider**	**:CITICARE MEDICAL CENTER LLC**
Policy Holder	**: MANJUSHA ADLAKHA NARAYAN LAL ADLAKHA**	**Doctor's Name**	**:MOHAMMED M HAMED**
Payer Name	**: TAKAFUL EMARAT**	**Co-Insurance**	**:**
TPA	**: E CARE - Blue Network**	**Remarks**	**:**
Validity	**: 31-07-2024** To **30-07-2025**		
Gender	**: Female**		
Date Of Birth	**: 17-Oct-1979**		
Patient's Tel No	**: 0523668349**		

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 : the patient came complaining of alternative amenorrhea and menometrorrhagia for the last 6 months she has a history of hypothyroidism and is taking eltroxine 150 daily she has a neck swelling and also complaining of hypersenstivity reactions and autoimmune symptoms she has a previous ultrasound showing multiple fibroids **Duration:**

Vitals:

Clinical Findings:

Diagnosis: N93.9 - Abnormal uterine and vaginal bleeding, unspecified,E03.9 - Hypothyroidism, unspecified,N77.1 - Vaginitis, vulvitis and vulvovaginitis in dis classd elswhr, **Date of Onset** :15/48/2024

Requested Investigations: 10, Consultation Specialist,84443, THYROID STIMULATING HORMONE TSH,86039, ANTINUCLEAR ANTIBODIES ANA TITER,76705, ULTRASOUND ABDOMINAL REAL TIME W/IMAGE LIMITED,76830, ULTRASOUND TRANSVAGINAL **Estimated Cost** :

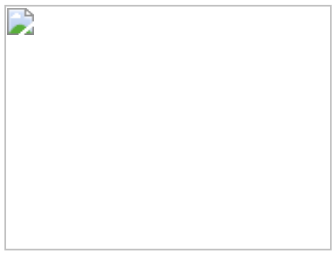
Prescriptions: **Estimated Cost** :

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 : MOHAMMED M HAMED **Stamp :**

Signature :



Date : 15-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 : 15-Oct-2024