Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	**: Shrimali Jyoti**
Card No	**: X5635653**
Policy Holder	**: Shrimali Jyoti**
Payer Name	**: TAKAFUL EMARAT**
TPA	**: E CARE - Blue Network**
Validity	**: 25-06-2024** To **24-06-2025**
Gender	**: Female**
Date Of Birth	**: 24-Mar-1975**
Patient's Tel No	**: 0508643515**

Service Date :04-Nov-2024 **Network** : Green

Health Provider :CITICARE MEDICAL CENTER LLC **Direct Access SP - YES**

Doctor's Name :Enomen Goodluck

Co-Insurance :

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

Remarks :

☐ **Acute** ☐ **Pre-existing and chronic** ☐ **Maternity**

Chief Complaints : Low back pain Duration: 4 days. There is no history of trauma, no fever, no recent increse in weight. There is no coughing. There is no tingling, no radiculopathy. Does not smoke no alcohol. Not hypertensive and not diabetic. **Duration:**

Vitals: Temp : 36.4 Bp :101 Pulse :87 Resp :18

Clinical Findings:

Diagnosis: M54.5 - Low back pain,M47.897 - Other spondylosis, lumbosacral region,N95.1 - Menopausal and female climacteric states, **Date of Onset** :04/37/2024

Requested Investigations: 82310, CALCIUM TOTAL,101, GENARAL WELNES CHECKUP (55 TEST),9, Consultation GP **Estimated Cost** :

Prescriptions: 2093-596002-0431 - (DICLOFENAC DIETHYLAMINE : 23.2 MG / G) GEL,1217-373201-2401 - (TOLPERISONE : 150 MG) SUGAR COATED TABLETS,0027-142201-2401 - (DICLOFENAC POTASSIUM : 50 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 : Enomen Goodluck **Stamp :**

Dr. Enomen Goodluck Ekata
General Practitioner
DHA No: 28040827-001
CITICARE MEDICAL CENTER LLC
DUBAI - U.A.E.

Patient 's signature{Parent if minor} : **Date :** 04-Nov-2024

Signature : **Date** : 04-Nov-2024