Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	: **BASSEM JAMIL KABBANI**	**Service Date**	:**20-Nov-2024**
Card No	: **I011-029-117910315-01**	**Health Provider**	:**CITICARE MEDICAL CENTER LLC**
Policy Holder	: **BASSEM JAMIL KABBANI**	**Doctor's Name**	:**Enomen Goodluck**
Payer Name	: **AL SAGR NATIONAL INSURANCE COMPANY**	**Co-Insurance**	:
TPA	: **ECARE-EBP EBP Enhanced CLASIC**	**Remarks**	:
Validity	: **27-12-2023** To **26-12-2024**		
Gender	: **Male**		
Date Of Birth	: **13-Nov-1987**		
Patient's Tel No	: **0568894601**		

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 : PC: Low back pain of sudden onset, said to have gone fishing and was pulling on a heavy object when he suddenly felt the pain and it has persisted since then. Duration: 2days (18/11/2024). Pain does not radiate to the lower limbs, there is no tingling nor pain down the lower limbs. Not hypertensive and not diabetic MRI is advised. **Duration:**

Vitals: Temp : 36.2 Bp :100 Pulse :96 Resp :18

Clinical Findings:

Diagnosis: M43.17 - Spondylolisthesis, lumbosacral region,M54.5 - Low back pain, **Date of Onset** :20/27/2024

Requested Investigations: 0005-149902-1021, CLOFEN ,96372, THER/PROPH/DIAG INJ SC/IM,9, Consultation GP **Estimated Cost** :

Prescriptions: 0027-149903-0111 - (DICLOFENAC SODIUM : 100 MG) COATED TABLETS,2093-596002-0431 - (DICLOFENAC DIETHYLAMINE : 23.2 MG / G GEL, **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 : Enomen Goodluck **Stamp :**

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

Signature : **Date** : 20-Nov-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 :** 20-Nov-2024