

Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name : VINAYAKA SHARMA
Service Date : 13-Jan-2025
Network : Green
Health Provider : CITICARE MEDICAL CENTER LLC
Direct Access SP - YES
Card No : I022-029-121718608-01
Doctor's Name : SANDIA
Co-Insurance :

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

Policy Holder : VINAYAKA SHARMA
Payer Name : TAKAFUL EMARAT
TPA : E CARE - Blue Network
Validity : 19-07-2024 To 18-07-2025
Gender : Male
Date Of Birth : 18-Mar-1997
Patient's Tel No : 0527014121

☐ Acute	☐ Pre-existing and chronic	☐ Maternity
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Chief Complaints : pc : stiffness in neck , lower back pain movement isnt restricted just pinful **Duration:** bp is elevated hx of tobacco smoking no other med condition counselled for bp monitoring

Vitals:Temp : 36.6 Bp :140 Pulse :72 Resp :18

Clinical Findings:

Diagnosis: M54.5 - Low back pain, **Date of Onset** : 13/58/2025

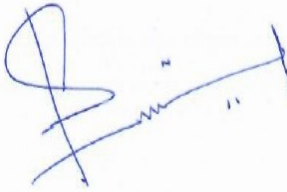
Requested Investigations: 9, Consultation GP **Estimated Cost** :

Prescriptions: 0321-379305-0511 - (THIAMINE (VITAMIN B1) : 100 MG/3 ML) (PYRIDOXINE (VITAMIN B6) : 100 MG/3 ML) (VITAMIN B12 : 1 MG/3 ML) INJECTION,0186-143701-0062 - **Cost** (CELECOXIB : 200 MG) CAPSULES,1217-373201-2401 - (TOLPERISONE : 150 MG) SUGAR COATED TABLETS,

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 : SANDIA **Stamp :** 

Signature :  **Date :** 13-Jan-2025

Patient 's signature{Parent : if minor}  **Date :** 13-Jan-2025