Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name : **VINAYAKA SHARMA ARVIND SHARMA**
Card No : **I022-029-121718608-01**
Policy Holder : **VINAYAKA SHARMA ARVIND 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**

Service Date :**13-Jan-2025** **Network** : Green
Health Provider :**CITICARE MEDICAL CENTER LLC** **Direct Access SP - YES**
Doctor's Name :**SANDIA**

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 : pc : stiffness in neck , lower back pain movement isnt restricted just pinful bp is elevated hx of tobacco smoking no other med condition counselled for bp monitoring **Duration:**

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

Clinical Findings:

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

Estimated Cost :

Requested Investigations: 9, Consultation GP

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 - (CELECOXIB : 200 MG) CAPSULES,1217-373201-2401 - (TOLPERISONE : 150 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.

Dr's Name : SANDIA **Stamp :**

Dr. Sandia Bhojwani
General Practitioner
DHA No: 65900212-001
PESHAWAR MEDICAL CENTER LLC
DUBAI - U.A.E.

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

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 :** 13-Jan-2025