Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	: AUNG MYO ZIN	**Service Date**	:26-Jan-2025	**Network**	: Green
Card No	: I017-029-121255243-01	**Health Provider**	:CITICARE MEDICAL CENTER LLC		**Direct Access SP - YES**
Policy Holder	: AUNG MYO ZIN	**Doctor's Name**	:DR Amaizah		
Payer Name	: ABU DHABI NATIONAL INSURANCE COMPANY-ADNIC	**Co-Insurance**	:		
TPA	: E CARE - Blue Network	**Remarks**	:		
Validity	: 26-08-2024 To 25-08-2025				
Gender	: Male				
Date Of Birth	: 01-May-1986				
Patient's Tel No	: 0529732283				

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 : pain and swelling of left toe for 2 days known gout arthritis bp elevated o/e : swollen tender left 3 rd toe **Duration:**

Vitals: Temp : 36 Bp :136 Pulse :86 Resp :18

Clinical Findings:

Diagnosis: M13.172 - Monoarthritis, not elsewhere classified, left ankle and foot,M79.672 - Pain in left foot,M1A.3791 - Chronic gout due to renal impairment, unsp ank/ft, w toph,R34 - Anuria and oliguria, **Date of Onset** :26/04/2025

Requested Investigations: 84550, Uric acid; blood,INJ051, INJ-HYDROCORTISONE 100 MG/2ML,0005-149902-1021, CLOFEN -(DICLOFENAC SODIUM : 75 MG/3ML) SOLUTION FOR INJECTION,80069, Renal function panel This panel must include the following: Albumin (82040), Calcium, total (82310), Carbon dioxide (bicarbonate) (82374), Chloride (82435), Creatinine (82565), Glucose (82947), Phosphorus inorganic (phosphate) (84100), Potassium (84132), Sodium (84295), Urea nitrogen (BUN) (84520),9, Consultation GP,84550, URIC ACID BLOOD,96372, THER/PROPH/DIAG INJ SC/IM,0005-149902-1021, CLOFEN ,80069, RENAL FUNCTION PANEL **Estimated Cost** :

Prescriptions: 0186-143703-1451 - (CELECOXIB : 400 MG) CAPSULES (HARD GELATIN),0005-119803-1173 - (PREDNISOLONE : 20 MG 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.

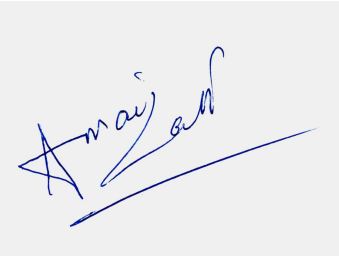
PATIENT'S DECLARATION :

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 : DR Amaizah **Stamp :**

Dr. Amaizah Ishtiaq
General Practitioner
DHA: 98486553-001
CITICARE MEDICAL CENTER
DUBAI - U.A.E

Patient 's signature{Parent if minor} : **Date :** 26-Jan-2025

Signature :  **Date** : 26-Jan-2025