

Administrative

Patient Name : DJAMEL SEHAD

Card No : I040-029-117807588-01

Policy Holder : DJAMEL SEHAD

Payer Name : UNION INSURANCE COMPANY

TPA : E CARE - Blue Network

Validity : 02-01-2025 To 01-01-2026

Gender : Male

Date Of Birth : 17-Nov-1994

Patient's Tel No : 0524408876

MEDICAL CLAIM FORM

Service Date :31-Jan-2025

Health Provider :CITICARE MEDICAL CENTER LLC

Doctor's Name :Humaira

Co-Insurance :

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

Remarks :

Claim Ref:

Network : Green

Direct Access SP - YES

☐ Acute

☐ Pre-existing and chronic

☐ Maternity

Chief Complaints : co back pain due to heavy weight lifting 24th jan. 2025 oe chest is clear no added sounds restless

Vitals:Temp : 36 Bp :148 Pulse :86 Resp :18

Clinical Findings:

Diagnosis: M62.830 - Muscle spasm of back,R52 - Pain, unspecified, Date of Onset : 31/40/2025

Requested Investigations: 0005-149902-1021, CLOFEN -(DICLOFENAC SODIUM : 75 MG/3ML) SOLUTION FOR INJECTION,96372, THER/PROPH/DIAG INJ SC/IM,9, Consultation GP Estimated Cost :

Prescriptions: 2093-596002-0432 - (DICLOFENAC DIETHYLAMINE : 23.2 MG / G) GEL,0278-107902-0391 - (IBUPROFEN : 400 MG) FILM COATED TABLETS,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.

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 : Humaira

Stamp :

Dr. Humaira Mumtaz

General Practitioner

DHA No: 54155530-002

CITICARE MEDICAL CENTER LLC

DUBAI - U.A.E.

Patient 's signature{Parent : if minor}

31-Jan-2025

Signature :

Date : 31-Jan-2025