Administrative

MEDICAL CLAIM FORM

Claim Ref:

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**

Service Date :**31-Jan-2025** **Network** : Green

Health Provider :**CITICARE MEDICAL CENTER LLC** **Direct Access SP - YES**

Doctor's Name :**Humaira**

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

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

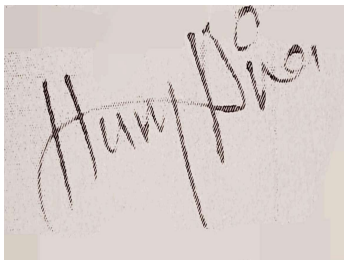
Stamp :

Dr. Humaira Mumtaz
General Practitioner
DHA No: 54155530-002
CITICARE MEDICAL CENTER LLC
DUBAI - U.A.E.

Patient 's signature{Parent if minor} :

Date : 31-Jan-2025

Signature :



Date : 31-Jan-2025