

Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name : ADEEL ASHRAF
Card No : I040-029-119910860-01
Policy Holder : ADEEL ASHRAF
Payer Name : UNION INSURANCE COMPANY
TPA : E CARE-Medium- Gold and Silver
Validity : 13-01-2025 To 12-01-2026
Gender : Male
Date Of Birth : 03-Sep-1990
Patient's Tel No : 0543702807

Service Date :10-Feb-2025

Network

: Green

Health Provider :CITICARE MEDICAL CENTER LLC

Direct Access SP - YES

Doctor's Name :DR Amaizah

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 : lower back pain , after lifting heavy object no other ned conditions Duration :

Vitals:Temp : 36.2 Bp :140 Pulse :76 Resp :18

Clinical Findings:

Diagnosis: M54.5 - Low back pain,R50.9 - Fever, unspecified,

Date of Onset : 10/06/2025

Requested Investigations: 0005-149902-1021, CLOFEN ,96372, THER/PROPH/DIAG INJ SC/IM,9, Consultation GP

Estimated :
Cost

Prescriptions: 0207-533802-1451 - (ESOMEPRAZOLE (AS MAGNESIUM : 40 MG CAPSULES (HARD GELATIN,2093-596002-0432 - (DICLOFENAC DIETHYLAMINE : 23.2 MG / G) GEL,3819-373201-0391 - (TOLPERISONE HCL : 150 MG) FILM COATED TABLETS,0186-143701-0062 - (CELECOXIB : 200 MG CAPSULES,

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.

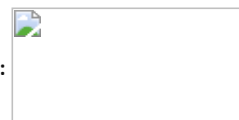
PATIENT'S DECLARATION :

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.

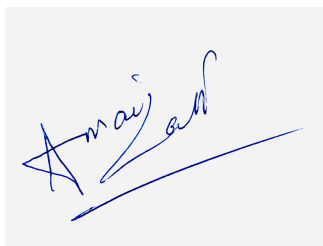
Dr's Name : DR Amaizah

Stamp :

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

Patient's signature{Parent :
if minor}10-
Date : Feb-
2025

Signature :



Date : 10-Feb-2025