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} : **Date** : 10-Feb-2025

Signature : **Date** : 10-Feb-2025