

Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name

JULIE ROSE SUMANG FLORES

Card No

: I017-029-120820677-01

Policy Holder

: JULIE ROSE SUMANG FLORES

Payer Name

: ABU DHABI NATIONAL INSURANCE COMPANY-ADNIC

TPA

: E CARE - Blue Network

Validity

: 21-05-2024 To 22-05-2025

Gender

: Female

Date Of Birth

: 07-Oct-1979

Patient's Tel No

: 0502402893

Service Date

:04-Mar-2025

Health Provider

:CITICARE MEDICAL CENTER LLC

Doctor's Name

:DR Amaizah

Co-Insurance

Network

: Green

Direct Access SP

- YES

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 : HEAVY VGINAL BLEEDING WITH REGULAR CYCLE , HAPPENED FOR THE DURATION: FIRD T TIME BP IS ELEVATED O/E : LOOK PALE . NO VISCERA PALPABLE

Vitals

:Temp : 36.6 Bp :132 Pulse :80 Resp :18

Clinical Findings:

Diagnosis

: N93.9 - Abnormal uterine and vaginal bleeding, unspecified,R03.0 - Elevated blood-pressure reading, w/o diagnosis of htn, Date of Onset :04/29/2025

Requested Investigations

: 85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,80061, LIPID PANEL,9, Consultation GP,85610, PROTHROMBIN TIME,85347, COAGULATION TIME ACTIVATED Estimated Cost :

Prescriptions:

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.

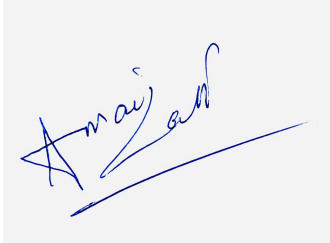
Dr's Name

: DR Amaizah

Stamp :

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

Signature :



Date

: 04-Mar-2025

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.

Patient 's signature{Parent : if minor}



Date

: 04-Mar-2025