Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	: **JULIE ROSE SUMANG FLORES**	**Service Date**	**:04-Mar-2025** **Network** : Green
Card No	: **I017-029-120820677-01**	**Health Provider**	**:CITICARE MEDICAL CENTER LLC** **Direct Access SP - YES**
Policy Holder	: **JULIE ROSE SUMANG FLORES**	**Doctor's Name**	**:DR Amaizah**
Payer Name	: **ABU DHABI NATIONAL INSURANCE COMPANY-ADNIC**	**Co-Insurance**	:
TPA	: **E CARE - Blue Network**	**Remarks**	:
Validity	: **21-05-2024** To **22-05-2025**		
Gender	: **Female**		
Date Of Birth	: **07-Oct-1979**		
Patient's Tel No	: **0502402893**		

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

☐ **Acute** ☐ **Pre-existing and chronic** ☐ **Maternity**

Chief Complaints : PC : HEAVY VGINAL BLEEDING WITH REGULAR CYCLE , HAPPENED FOR THE FIRDT TIME BP IS ELEVATED O/E : LOOK PALE . NO VISCERA PALPABLE **Duration:**

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: **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** : 04-Mar-2025

Signature : **Date** : 04-Mar-2025