Administrative

MEDICAL CLAIM FORM

Claim Ref:

Direct Access SP - YES

: JULIE ROSE SUMANG FLORES **Patient** Name

: 1017-029-120820677-01

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

Card No JULIE ROSE SUMANG Policy

Holder **FLORES**

ABU DHABI NATIONAL Payer : INSURANCE COMPANY-Name

ADNIC

: E CARE - Blue Network TPA

Gender : Female Date Of

Birth

Validity

: 07-Oct-1979

Service

:07-Mar-2025 Date

Health

Provider

Doctor's

Insurance

Remarks

Name

Co-

Network

:Green

:CITICARE MEDICAL CENTER LLC

:MOHAMMED M HAMED

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

Patient's Tel No	: 0502402893				
☐ Acute	Pre-existing and chronic		☐ Maternity		
G2P2 NVD T PALPITAION		ing of bleeding excessively since one month d pressure, PATIENT CAME WITH HYPERTENSIO G FOR 5 DAYS	Duration: DN		
Clinical Find	<u> </u>				
vaginal blee	ding, unspecified,D64.9 - Anemia, ι		Onset		
ULTRASOUN		sultation GP,10, Consultation Specialist,76830, IUND ABDOMINAL REAL TIME W/IMAGE IO&AUTO DIFRNTL WBC COUNT	, Estimated : Cost		
386001-039	•	IIC ACID : 500 MG) FILM COATED TABLETS,311 LO MG FILM COATED TABLETS,6445-379201-11			
I declare th	RACTITIONER DECLARATION: at I am the patient's medical practit my knowledge true and correct.	ioner and that the particulars given are to	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 :	MOHAMMED M HAMED	Dr. Mohammed M Hamed Hashish Specialist Obstetrics And Gynecology DHA No: 75385955-001 CITICARE MEDICAL CENTER LLC DUBAI - U.A.E.	Patient 's signature{Parent: if minor} 07- Date: Mar- 2025		
Signature :		Date : 07-Mar-2025			