Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	: **JULIE ROSE SUMANG FLORES**	**Service Date**	**:07-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**	**:MOHAMMED M HAMED**		
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 : the patient comes complaining of bleeding excessively since one month G2P2 NVD THE patient has a slight ruse in blood pressure, PATIENT CAME WITH HYPERTENSION PALPITAION SHE HAS HEAVY VAGINAL BLEEDING FOR 5 DAYS **Duration:**

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

Clinical Findings:

Diagnosis: I10 - Essential (primary) hypertension,E78.5 - Hyperlipidemia, unspecified,N93.9 - Abnormal uterine and vaginal bleeding, unspecified,D64.9 - Anemia, unspecified, **Date of Onset** :07/38/2025

Requested Investigations: 9.01, Follow Up Consultation GP,10, Consultation Specialist,76830, ULTRASOUND TRANSVAGINAL,76705, ULTRASOUND ABDOMINAL REAL TIME W/IMAGE LIMITED,85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT **Estimated Cost** :

Prescriptions: 0154-217001-1171 - (DESOGESTREL : 0.15 MG) (ETHINYL ESTRADIOL : 0.03 MG) TABLETS,2212-156802-0391 - (TRANEXAMIC ACID : 500 MG) FILM COATED TABLETS,3114-386001-0391 - (ATORVASTATIN (AS CALCIUM : 10 MG FILM COATED TABLETS,6445-379201-1171 - (AMLODIPINE (AS BESYLATE : 5 MG TABLETS, **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.

Dr's Name : MOHAMMED M HAMED **Stamp :**

Dr. Mohammed M Hamed Hashish
Specialist Obstetrics And Gynecology
DHA No: 75385955-001
CITICARE MEDICAL CENTER LLC
DUBAI - U.A.E.

Signature :  **Date** : 07-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 :** 07-Mar-2025