Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	: **HOUSSAM KHODER MUSTAFA EL MIR**	**Service Date**	:**13-Mar-2025** **Network** : Green
Card No	: **I022-029-112671422-01**	**Health Provider**	:**CITICARE MEDICAL CENTER LLC** **Direct Access SP - YES**
Policy Holder	: **HOUSSAM KHODER MUSTAFA EL MIR**	**Doctor's Name**	:**AISHA**
Payer Name	: **TAKAFUL EMARAT**	**Co-Insurance**	:
TPA	: **E CARE - Green Network**	**Remarks**	:
Validity	: **01-03-2025** To **28-02-2026**		
Gender	: **Male**		
Date Of Birth	: **01-Jan-1967**		
Patient's Tel No	: **971554300118**		

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 : PATIENT CAME WITH THE COMPLAIN NECK PAIN ALONG WITH SCAPULAR MUSCLE SPASM TENDERNESS LIMITED SHOULDER MOVEMENT **Duration:**

Vitals: Temp : 36.6 Bp :106 Pulse :83 Resp :18

Clinical Findings:

Diagnosis: M62.830 - Muscle spasm of back,M25.512 - Pain in left shoulder, **Date of Onset** :13/56/2025

Requested Investigations: 0005-149902-1021, CLOFEN -(DICLOFENAC SODIUM : 75 MG/3ML) SOLUTION FOR INJECTION,96372, THER/PROPH/DIAG INJ SC/IM,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE-(DEXAMETHASONE : 4 MG/ML) SOLUTION FOR INJECTION,9, Consultation GP **Estimated Cost** :

Prescriptions: 2093-596002-0431 - (DICLOFENAC DIETHYLAMINE : 23.2 MG / G GEL,0009-122302-0391 - (ETORICOXIB : 120 MG FILM COATED TABLETS,3819-373201-0391 - (TOLPERISONE HCL : 150 MG FILM COATED 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.

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 : AISHA

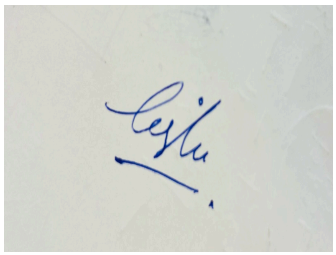
Stamp :

Dr. Aisha Umer
Physician- General Practitioner
DHA- 40131439-002
CITICARE MEDICAL CENTER
DUBAI - U.A.E

Patient 's signature{Parent if minor} :

Date : 13-Mar-2025

Signature :



Date : 13-Mar-2025