Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	**: EMAN ZAHRA**
Card No	**: I005-029-122018584-01**
Policy Holder	**: EMAN ZAHRA**
Payer Name	**: DUBAI INSURANCE COMPANY**
TPA	**: E CARE - Blue Network**
Validity	**: 10-09-2024** To **09-09-2025**
Gender	**: Female**
Date Of Birth	**: 27-Feb-2025**
Patient's Tel No	**: 0504900869**

Service Date **:18-Mar-2025** **Network** **:** Green

Health Provider **:CITICARE MEDICAL CENTER LLC** **Direct Access SP - YES**

Doctor's Name **:AISHA**

Co-Insurance :

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 : CO. NAUSEA DIZZINESS .ALONG WITH BACK PAIN IRREGULAR PERIODS ALSO COMPLAIN OF MUSCLE CRAMPS **Duration:**

Vitals: Temp : 37 Bp :107 Pulse :92 Resp :0

Clinical Findings:

Diagnosis: R11.10 - Vomiting, unspecified,R11.2 - Nausea with vomiting, unspecified,M54.5 - Low back pain,M62.838 - Other muscle spasm,D50.9 - Iron deficiency anemia, unspecified,N91.2 - Amenorrhea, unspecified, **Date of Onset** **:**18/09/2025

Requested Investigations: 85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,84704, HCG FREE BETACHAIN TEST,84443, THYROID STIMULATING HORMONE TSH,84481, TRIIODOTHYRONINE T3 FREE,84480, TRIIODOTHYRONINE T3 TOTAL TT3,9, Consultation GP **Estimated Cost** **:**

Prescriptions: 0321-100604-1171 - (VITAMIN B12 : 200 MCG) (THIAMINE (VITAMIN B1) : 100 MG) (PYRIDOXINE (VITAMIN B6) : 200 MG) TABLETS,3819-373201-0391 - (TOLPERISONE HCL : 150 MG FILM COATED TABLETS,0006-106601-0393 - (PARACETAMOL : 500 MG) FILM COATED TABLETS,0097-397801-0392 - (DOMPERIDONE (AS MALEATE : 10 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

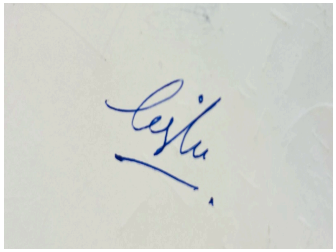
Stamp :

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

Patient 's signature{Parent if minor} :

Date : 18-Mar-2025

Signature :



Date : 18-Mar-2025