

Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name : THI HA AUNG

Card No : I040-029-120585630-01

Policy Holder : THI HA AUNG

Payer Name : UNION INSURANCE COMPANY

TPA : E CARE - Blue Network

Validity : 02-01-2025 To 01-01-2026

Gender : Male

Date Of Birth : 16-Feb-2001

Patient's Tel No : 0559542312

Service Date :06-Apr-2025

Health Provider :CITICARE MEDICAL CENTER LLC

Doctor's Name :AISHA

Co-Insurance :

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

Remarks :

Network : Green

Direct Access SP - YES

☐ Acute

☐ Pre-existing and chronic

☐ Maternity

Chief Complaints : patient have a complain low back pain for one week he is a housekeeper used to lift heavy weight

Duration:

Vitals:Temp : 36.6 Bp :120 Pulse :84 Resp :18

Clinical Findings:

Diagnosis: M54.5 - Low back pain,M62.830 - Muscle spasm of back,

Date of Onset :06/56/2025

Requested Investigations: 0005-149902-1021, CLOFEN -(DICLOFENAC SODIUM : 75 MG/3ML) SOLUTION FOR INJECTION,96372, THER/PROPH/DIAG INJ SC/IM,9, Consultation GP

Estimated Cost :

Prescriptions: 0278-107902-0391 - (IBUPROFEN : 400 MG) FILM COATED TABLETS,2093-596002-0431 - (DICLOFENAC DIETHYLAMINE : 23.2 MG / G) GEL,1217-373201-2401 - (TOLPERISONE : 150 MG) SUGAR 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.

Dr's Name : AISHA

Stamp :

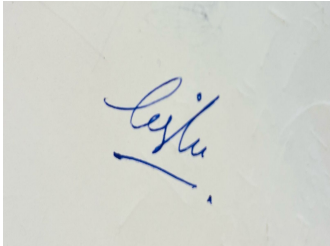
Dr. Aisha Umer

Physician- General Practitioner

DHA- 40131439-002

CITICARE MEDICAL CENTER

DUBAI - U.A.E

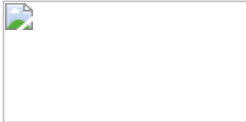
Signature :

Date : 06-Apr-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 : Apr-2025