Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	: **MOHAMMAD EHTISHAAM AHMAD JUNAID AHMAD**	**Service Date**	**:10-Apr-2025**	**Network**	: Green
Card No	: **I040-029-113861887-01**	**Health Provider**	**:CITICARE MEDICAL CENTER LLC**	**Direct Access SP - YES**	
Policy Holder	: **MOHAMMAD EHTISHAAM AHMAD JUNAID AHMAD**	**Doctor's Name**	**:Humaira**		
Payer Name	: **UNION INSURANCE COMPANY**	**Co-Insurance**	:		
TPA	: **ECARE-EBP EBP Enhanced CLASIC**	**Remarks**	:		
Validity	: **13-01-2025** To **12-01-2026**				
Gender	: **Male**				
Date Of Birth	: **22-Nov-1997**				
Patient's Tel No	: **0542318198**				

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 in the morning with epigastric pain took injections pain is settle. now complain of back pain which is going down. **Duration:**

Vitals:

Clinical Findings:

Diagnosis: M54.5 - Low back pain, **Date of Onset** : 10/19/2025

Requested Investigations: 0005-149902-1021, CLOFEN ,96372, THER/PROPH/DIAG INJ SC/IM,9.01, Follow Up Consultation GP **Estimated Cost** :

Prescriptions: 0097-142201-0391 - (DICLOFENAC POTASSIUM : 50 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.

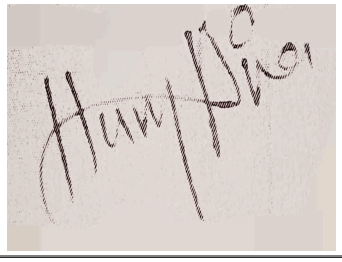
PATIENT'S DECLARATION :

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 : Humaira **Stamp :**

Dr. Humaira Mumtaz
General Practitioner
DHA No: 54155530-002
CITICARE MEDICAL CENTER LLC
DUBAI - U.A.E.

Patient 's signature{Parent if minor} : **Date :** 10-Apr-2025

Signature :  **Date** : 10-Apr-2025