Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	**: MAZEN NAEM YACOUB**	**Service Date**	**:16-Apr-2025**	**Network**	**:** Green
Card No	**: I017-029-120389126-03**	**Health Provider**	**:CITICARE MEDICAL CENTER LLC**		**Direct Access SP - YES**
Policy Holder	**: MAZEN NAEM YACOUB**	**Doctor's Name**	**:DR Amaizah**		
Payer Name	**: ABU DHABI NATIONAL INSURANCE COMPANY-ADNIC**	**Co-Insurance**	:		
TPA	**: E CARE - Green Network**	**Remarks**	:		
Validity	**: 06-01-2025** To **05-01-2026**				
Gender	**: Male**				
Date Of Birth	**: 20-Feb-1982**				
Patient's Tel No	**: 0551723654**				

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 : pc : severe bodypain , back pain , associated with fever **Duration :**

Vitals: Temp : 37.9 Bp :120 Pulse :86 Resp :18

Clinical Findings:

Diagnosis: J06.9 - Acute upper respiratory infection, unspecified,R52 - Pain, unspecified,M54.5 - Low back pain, **Date of Onset :**16/17/2025

Requested Investigations: 85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,86140, C REACTIVE PROTEIN,9, Consultation GP **Estimated Cost :**

Prescriptions: 1195-926901-0391 - (VITAMIN D3 : 5 MCG) (VITAMIN E (AS D-ALPHA TOCOPHERYL SUCCINATE) : 20 MG) (ZINC : 15 MG) (CHROMIUM : 50 MCG) (COPPER : 1 MG) (VITAMIN B12 : 9 MCG) (FOLACIN : 500 MCG) (SIBERIAN GINSENG (ELEUTHEROCOCCUS SENTICOSUS) : 20 MG) (IODINE : 150 MCG) (IRON (FERROUS FUMARATE) : 6 MG) (MAGNESIUM OXIDE : 50 MG) (MANGANESE SULFATE : 3 MG) (L-METHIONINE : 20 MG) (NIACIN : 20 MG) (PANTOTHENIC ACID : 10 MG) (PABA : 20 MG) (PYRIDOXINE (VITAMIN B6) : 9 MG) (VITAMIN B2 (RIBOFLAVIN) : 5 MG) (SELENIUM : 150 MCG) (S,2027-560101-0392 - (IBUPROFEN : 150 MG) (PARACETAMOL : 500 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 : DR Amaizah **Stamp :**

Dr. Amaizah Ishtiaq
General Practitioner
DHA: 98486553-001
CITICARE MEDICAL CENTER
DUBAI - U.A.E

Patient 's signature{Parent if minor} : **Date :** 16-Apr-2025

Signature : **Date :** 16-Apr-2025