Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	**: CHARLENE RAMSAMY**
Card No	**: I005-029-118918862-01**
Policy Holder	**: CHARLENE RAMSAMY**
Payer Name	**: DUBAI INSURANCE COMPANY**
TPA	**: E CARE - Blue Network**
Validity	**: 16-10-2024** To **15-10-2025**
Gender	**: Female**
Date Of Birth	**: 30-Jul-1980**
Patient's Tel No	**: 0557230485**

Service Date :**02-May-2025** **Network** : Green

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

Doctor's Name :**Dr.Farhan Iyas**

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 : heavy menstrual periods since last night previously not that heavy lower abdominal pain weakness dizziness dehydrated **Duration:**

Vitals: Temp : 36.6 Bp :134 Pulse :84 Resp :18

Clinical Findings:

Diagnosis: N92.0 - Excessive and frequent menstruation with regular cycle,R10.30 - Lower abdominal pain, unspecified,R53.1 - Weakness,E86.0 - Dehydration, **Date of Onset** :02/08/2025

Requested Investigations: 0439-152905-1001, LACTATED RINGERS INJECTION USP,0005-149902-1021, CLOFEN ,96360, HYDRATION IV INFUSION INIT,0005-136504-1021, SCOPINAL,96372, THER/PROPH/DIAG INJ SC/IM,9, Consultation GP **Estimated Cost** :

Prescriptions: 0097-142201-0391 - (DICLOFENAC POTASSIUM : 50 MG) FILM COATED TABLETS,0005-136501-0391 - (HYOSCINE : 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.

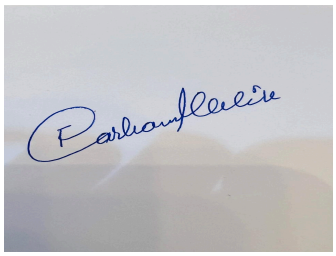
PATIENT'S DECLARATION :

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 : Dr.Farhan Iyas **Stamp :**

Dr .Frahan Ilyas Malik
Physician-General Practitioner
DHA-06441782-001
CITICARE MEDICAL CENTER
DUBAI U.A.E

Patient 's signature{Parent if minor} : **Date** : 02-May-2025

Signature :  **Date** : 02-May-2025