## Administrative MEDICAL CLAIM FORM Claim Ref:

| | | | |
|---|---|---|---|
| **Patient Name** | : **HENDRIX JULES THOMAS FRECHETTE** | **Service Date** | **:21-May-2025** **Network** : Green |
| **Card No** | : **784-2020-3838610-2** | **Health Provider** | **:CITICARE MEDICAL CENTER LLC** **Direct Access SP - YES** |
| **Policy Holder** | : **HENDRIX JULES THOMAS FRECHETTE** | **Doctor's Name** | **:Dr Bushra** |
| **Payer Name** | : **ABU DHABI NATIONAL INSURANCE COMPANY-ADNIC** | **Co-Insurance** | : |
| **TPA** | : **E CARE - Blue Network** | **Remarks** | : |
| **Validity** | : **19-03-2025** To **18-03-2026** | | |
| **Gender** | : **Male** | | |
| **Date Of Birth** | : **01-Sep-2020** | | |
| **Patient's Tel No** | : **0585924925** | | |

| 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 :** history of fall right mid shaft clavicular fracture **Duration :**

**Vitals:**Temp : 37 Bp :0 Pulse :86 Resp :22

**Clinical Findings:**

**Diagnosis:** S42.021A - Disp fx of shaft of right clavicle, init for clos fx,E55.9 - Vitamin D deficiency, unspecified, **Date of Onset :**21/48/2025

**Requested Investigations:** 9, Consultation GP,9, Consultation GP,9, Consultation GP **Estimated Cost :**

**Prescriptions:** 0444-176502-1381 - (VITAMIN D3 : 400 IU) SOLUTION (ORAL), **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** : Dr Bushra **Stamp :**

Dr. Bushra Mufti
General practitioner
DHA: 75646242-001
CITICARE MEDICAL CENTER
DUBAI - U.A.E

**Signature :**  **Date** : 21-May-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 :** 21-May-2025