

Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name : HENDRIX JULES THOMAS
Card No : 784-2020-3838610-2
Policy Holder : HENDRIX JULES THOMAS
Payer Name : ABU DHABI NATIONAL INSURANCE COMPANY-ADNIC
TPA : E CARE - Blue Network
Validity : 19-03-2025 To 18-03-2026
Gender : Male
Date Of Birth : 01-Sep-2020
Patient's Tel No : 0585924925

Service Date : 21-May-2025
Health Provider : CITICARE MEDICAL CENTER LLC
Doctor's Name : Dr Bushra

Network : Green
Direct Access SP - YES

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

Co-Insurance :

Remarks :

☐ 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

Estimated Cost :

Requested Investigations: 9, Consultation GP,9, Consultation GP,9, Consultation GP

Estimated Cost :

Prescriptions: 0444-176502-1381 - (VITAMIN D3 : 400 IU) SOLUTION (ORAL),

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 :

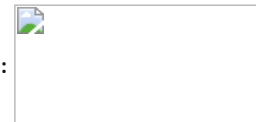
I hereby authorize any Healthcare provider, Insurer, Employer or other organization to release any information regarding my medical condition & history for purpose of determining insurance benefits.

Dr's Name : Dr Bushra

Stamp :

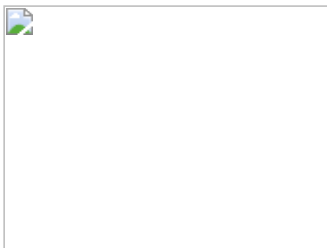
Dr. Bushra Mutti
 General practitioner
 DHA: 75646242-001
 CITICARE MEDICAL CENTER
 DUBAI - U.A.E

Patient 's signature{Parent : if minor}



Date : 21-May-2025

Signature :



Date : 21-May-2025