Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	**: JANELLE THOMAS**	**Service Date**	**:21-May-2025**
Card No	**: 784-1978-8386848-7**	**Health Provider**	**:CITICARE MEDICAL CENTER LLC**
Policy Holder	**: JANELLE THOMAS**	**Doctor's Name**	**:Dr.Farhan Iyas**
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	**: Female**		
Date Of Birth	**: 22-May-1978**		
Patient's Tel No	**: 0585924925**		

Network : Green

Direct Access SP - YES

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 : irregular menstural cycle depression insomnia fatigue lethargy mood swings **Duration:**

Vitals: Temp : 36.1 Bp :124 Pulse :84 Resp :18

Clinical Findings:

Diagnosis: N92.6 - Irregular menstruation, unspecified, **Date of Onset** : 21/55/2025

Requested Investigations: 83001, FOLLICLE STIMULATING HORMONE (FSH), SERUM,83002, LUTEINIZING HORMONE (LH), SERUM,84146, PROLACTIN, SERUM,85025, COMPLETE BLOOD COUNT (CBC), BLOOD,9, Consultation GP,459, BLOOD PACKAGE -459,9, Consultation GP **Estimated Cost** :

Prescriptions: **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.

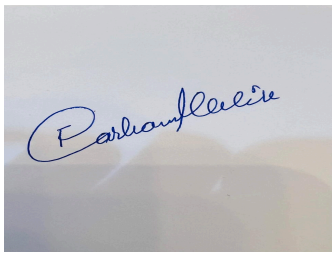
Dr's Name : Dr.Farhan Iyas

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 : 21-May-2025

Signature : 

Date : 21-May-2025