Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	**: JANELLE THOMAS**	**Service Date**	**:30-May-2025**
Card No	**: 784-1978-8386848-7**	**Health Provider**	**:CITICARE MEDICAL CENTER LLC**
Policy Holder	**: JANELLE THOMAS**	**Doctor's Name**	**:DR Amaizah**
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**		

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

Network : Green

Direct Access SP - YES

☐ **Acute** ☐ **Pre-existing and chronic** ☐ **Maternity**

Chief Complaints : follow up for labs **Duration :**

Vitals: Temp : 37 Bp :120 Pulse :84 Resp :18

Clinical Findings:

Diagnosis: G47.00 - Insomnia, unspecified,E55.9 - Vitamin D deficiency, unspecified,R73.03 - Prediabetes, **Date of Onset :**30/20/2025

Requested Investigations: INJ064, VITAMIN D, INJECTION ,96372, INJECTION SERVICE-IM,9, Consultation GP **Estimated Cost :**

Prescriptions: 2654-636101-0061 - (STARFLOWER OIL : 100 MG) (EVENING PRIMROSE OIL : 100 MG) (VITAMIN D3 : 5 MCG) (VITAMIN E : 30 MG) (VITAMIN C : 60 MG) (THIAMINE (VITAMIN B1) : 10 MG) (RIBOFLAVINE (VITAMIN B2) : 5 MG) (NIACIN : 36 MG) (VITAMIN B6 : 10 MG) (FOLACIN : 400 MCG) (VITAMIN B12 : 20 MCG) (BIOTIN : 50 MCG) (PANTOTHENIC ACID : 6 MG) (VITAMIN K : 90 MCG) (NATURAL MIXED CAROTENOIDS : 2 MG) (IRON : 12 MG) (MAGNESIUM : 100 MG) (ZINC : 12 MG) (MANGANESE : 2.5 MG) (COPPER : 1.5 MG) (SELENIUM : 100 MCG) (CHROMIUM : 50 MCG) (PA,5278-164103-0362 - (METFORMIN HCL : 500 MG) EXTENDED RELEASE 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 :

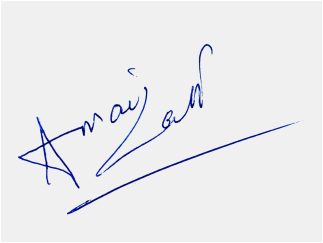
I hereby authorize any Healthcare provider, Insurer, Employer or other organization to release any information regarding my medical condition & history for purpose of determining insurance benefits.

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 : 30-May-2025

Signature :  **Date :** 30-May-2025