Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	**: NAREEKA KAINTH**
Card No	**: I040-029-121210616-01**
Policy Holder	**: NAREEKA KAINTH**
Payer Name	**: UNION INSURANCE COMPANY**
TPA	**: E CARE - Blue Network**
Validity	**: 05-02-2025** To **04-02-2026**
Gender	**: Female**
Date Of Birth	**: 07-Aug-1994**
Patient's Tel No	**: 0503567708**

Service Date **:01-Jun-2025** **Network** : Green

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

Doctor's Name **:AISHA**

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 : pt came with left low back pain for the last four month she is doing continous expercise . normal micturation **Duration:**

Vitals: Temp : 36.9 Bp :111 Pulse :66 Resp :18

Clinical Findings:

Diagnosis: M54.5 - Low back pain,M62.830 - Muscle spasm of back,E83.51 - Hypocalcemia,E55.9 - Vitamin D deficiency, unspecified,R53.1 - Weakness,E03.9 - Hypothyroidism, unspecified, **Date of Onset** **:**01/05/2025

Requested Investigations: 84443, THYROID STIMULATING HORMONE TSH,84481, TRIIODOTHYRONINE T3 FREE,82310, CALCIUM TOTAL,82306, 25 HYDROXY INCLUDES FRACTIONS IF PERFORMED,9, Consultation GP **Estimated Cost** :

Prescriptions: 2093-596002-0432 - (DICLOFENAC DIETHYLAMINE : 23.2 MG / G) GEL,0027-142201-0832 - (DICLOFENAC POTASSIUM : 50 MG) POWDER FOR SOLUTION,3819-373201-0391 - (TOLPERISONE HCL : 150 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 : AISHA

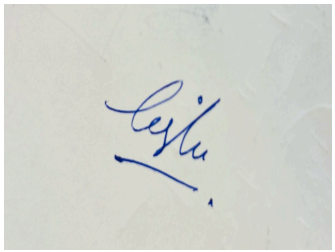
Stamp :

Dr. Aisha Umer
Physician- General Practitioner
DHA- 40131439-002
CITICARE MEDICAL CENTER
DUBAI - U.A.E

Patient 's signature{Parent : if minor}

Date : 01-Jun-2025

Signature :



Date : 01-Jun-2025