

Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name : SHUBHAM THAKAR SOM RAJ

Card No : I040-029-121616018-01

Policy Holder : SHUBHAM THAKAR SOM RAJ

Payer Name : UNION INSURANCE COMPANY

TPA : E CARE - Blue Network

Validity : 02-01-2025 To 01-01-2026

Gender : Male

Date Of Birth : 15-Jul-1996

Patient's Tel No : 0529558657

Service Date :02-Jun-2025

Health Provider :CITICARE MEDICAL CENTER LLC

Doctor's Name :DR Amaizah

Co-Insurance :

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

Remarks :

Network : Green

Direct Access SP - YES

☐ Acute

☐ Pre-existing and chronic

☐ Maternity

Chief Complaints : pc : low back pain , cauing difficulty in walking and standing started 30/05/25 taking panadol not improved o/e : look irritable due to pain

Vitals:Temp : 36.6 Bp :116 Pulse :78 Resp :18

Clinical Findings:

Diagnosis: M54.5 - Low back pain,M62.830 - Muscle spasm of back,

Requested Investigations: 0005-149902-1021, CLOFEN ,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE,96372, THER/PROPH/DIAG INJ SC/IM,9, Consultation GP

Prescriptions: 0027-149903-0391 - (DICLOFENAC SODIUM : 100 MG) FILM COATED TABLETS,3819-373201-0391 - (TOLPERISONE HCL : 150 MG) FILM COATED TABLETS,

Duration:

Date of Onset :02/46/2025

Estimated : Cost

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 Amaizah

Stamp :

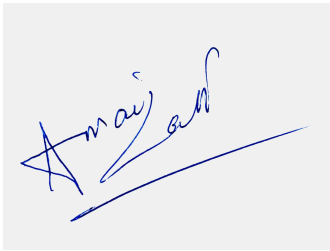
Dr. Amaizah Ishtiaq

General Practitioner

DHA: 98486553-001

CITICARE MEDICAL CENTER

DUBAI - U.A.E

Signature :

Date : 02-Jun-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}



02-Jun-2025

Date : Jun-2025