Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	**: AMINA MOHAMED ABDELAZIM ABDELMAQSOUD**
Card No	**: I017-029-121075946-03**
Policy Holder	**: AMINA MOHAMED ABDELAZIM ABDELMAQSOUD**
Payer Name	**: ABU DHABI NATIONAL INSURANCE COMPANY-ADNIC**
TPA	**: E CARE - Green Network**
Validity	**: 06-01-2025** To **05-01-2026**
Gender	**: Female**
Date Of Birth	**: 05-Aug-1998**
Patient's Tel No	**: 547977506**

Service Date **:05-Jul-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 : pc : left hand thumb numbness hopc : pt came with left hand thumb numbness and loss of sensation o/e power is f/f pin prick sensation is affected **Duration:**

Vitals: Temp : 36.6 Bp :130 Pulse :76 Resp :18

Clinical Findings:

Diagnosis: R20.2 - Paresthesia of skin,R53.1 - Weakness, **Date of Onset** : 05/13/2025

Estimated Cost :

Requested Investigations: 9, Consultation GP

Prescriptions: 5254-830602-2401 - (VITAMIN B1 (THIAMINE) : 100 MG) (VITAMIN B6 (AS PYRIDOXINE HCL) : 200 MG) (VITAMIN B12 (CYANOCOBALAMIN) : 200 MCG) SUGAR COATED TABLETS, **Estimated Cost** :

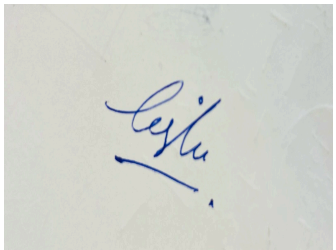
MEDICAL PRACTITIONER DECLARATION :

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.

Dr's Name : AISHA

Stamp :

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

Signature : 

Date : 05-Jul-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} :

Date : 05-Jul-2025