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 **:01-Aug-2025** **Network** : Green

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

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 :

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

Chief Complaints : PC : SEVRE LOWER ABDOMINAL PAIN CRAMPING IN NATURE STRATED 27/07/25 O/E : LOOK PALE , DEHYDRATED **Duration:**

Vitals: Temp : 36.4 Bp :130 Pulse :70 Resp :18

Clinical Findings:

Diagnosis: K29.00 - Acute gastritis without bleeding,R03.0 - Elevated blood-pressure reading, w/o diagnosis of htn,E78.5 - Hyperlipidemia, unspecified,E86.0 - Dehydration,R19.7 - Diarrhea, unspecified, **Date of Onset** :01/44/2025

Requested Investigations: 80061, LIPID PANEL,86140, C REACTIVE PROTEIN,85027, BLOOD COUNT COMPLETE AUTOMATED,9, Consultation GP **Estimated Cost** :

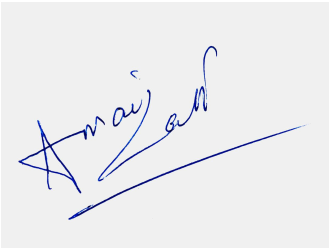
Prescriptions: 0415-200001-1452 - (LOPERAMIDE : 2 MG) CAPSULES (HARD GELATIN),0219-533801-0392 - (ESOMEPRAZOLE (AS MAGNESIUM) : 20 MG) FILM COATED TABLETS,6619-230505-0831 - (SODIUM CHLORIDE : 2.6 G) (POTASSIUM CHLORIDE : 1.5 G) (SODIUM CITRATE : 2.9 G) (DEXTROSE ANHYDROUS : 13.5 G) POWDER FOR SOLUTION,0005-136501-0393 - (HYOSCINE : 10 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.

Dr's Name : DR Amaizah **Stamp :**

Dr. Amaizah Ishtiaq
General Practitioner
DHA: 98486553-001
CITICARE MEDICAL CENTER
DUBAI - U.A.E

Signature :  **Date** : 01-Aug-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** : 01-Aug-2025