## Administrative MEDICAL CLAIM FORM Claim Ref:

| | | | | | |
|---|---|---|---|---|---|
| **Patient Name** | **: RACHEL BENDADA** | **Service Date** | **:22-Aug-2025** | **Network** | **:** Green |
| **Card No** | **: I017-029-121844166-01** | **Health Provider** | **:CITICARE MEDICAL CENTER LLC** | | **Direct Access SP - YES** |
| **Policy Holder** | **: RACHEL BENDADA** | **Doctor's Name** | **:HUMMAIRA** | | |
| **Payer Name** | **: ABU DHABI NATIONAL INSURANCE COMPANY-ADNIC** | **Co-Insurance** | : | | |
| **TPA** | **: E CARE - Blue Network** | **Remarks** | : | | |
| **Validity** | **: 07-02-2025** To **06-02-2026** | | | | |
| **Gender** | **: Female** | | | | |
| **Date Of Birth** | **: 21-May-1997** | | | | |
| **Patient's Tel No** | **: 0543268307** | | | | |

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

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

**Chief Complaints :** TRANSVAGINAL ULTRASOUND ; UTERUS NORMAL SIZE 4X3.7X3.5 CM ANTEVERTED ANTEFLEXED ENDOMETRIAL ECHO 5MM. LEFT BULKY POLYCYSTIC OVARY. RIGHT SIDE OVARY NORMAL., SERUM BETA HCG . HBA1C TRNAS VAGINAL SCAN., H/O WEIGHT GAIN . OVER WEIGHT BUT NOW DIETING., IN REALTONHIP LMP 21 ST JULY 2025 IRREGULAR PERIODS FOR LAST 5 MONTH. SOME TIME TWICE IN A MONTH. REDUCED FLOW BUT LASTED FOR 14 DAYS. STRONG FAMILY HISTORY OF DIABETES. P/S EXAMINATION COPIOUS THICK WHITE DISCHARGE. **Duration:**

**Vitals:**Temp : 36.8 Bp :130 Pulse :72 Resp :18

**Clinical Findings:**

**Diagnosis:** N92.6 - Irregular menstruation, unspecified,N91.2 - Amenorrhea, unspecified,Z32.00 - Encounter for pregnancy test, result unknown, **Date of Onset** :22/08/2025

**Requested Investigations:** 84702, B HCG (GONADOTROPIN CHORIONIC QUANTITATIVE),83036, HEMOGLOBIN GLYCOSYLATED A1C,76830, ULTRASOUND TRANSVAGINAL,10, Consultation Specialist **Estimated Cost** :

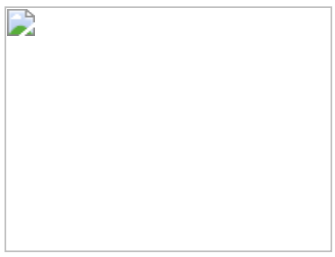
**Prescriptions:** 0096-140502-1242 - (CLOTRIMAZOLE : 100 MG) VAGINAL TABLETS,0005-185902-1172 - (FOLIC ACID : 5 MG) TABLETS, **Estimated Cost** :

**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** : HUMMAIRA **Stamp :**

**Signature :**



**Date** : 22-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 :** 22-Aug-2025