Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	**: Caleb Musyoki Nzengula**	**Service Date**	**:23-May-2024**
Card No	**: I017-029-116122171-02**	**Health Provider**	**:Irham Medical Center Arjan**
Policy Holder	**: Caleb Musyoki Nzengula**	**Doctor's Name**	**:Humaira**
Payer Name	**: ABU DHABI NATIONAL INSURANCE COMPANY-ADNIC**	**Co-Insurance**	**:**
TPA	**: E CARE - Green Network**	**Remarks**	**:**
Validity	**: 01-10-2023** To **30-09-2024**		
Gender	**: Male**		
Date Of Birth	**: 15-Aug-1988**		
Patient's Tel No	**: 0559096728**		

Network : Green

Direct Access SP - YES

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 : co lethargy thirsty week ill looking 1 week oe dehydration chest is clear no addded sounds vitals stable **Duration:**

Vitals:

Clinical Findings:

Diagnosis: R73.9 - Hyperglycemia, unspecified,E86.0 - Dehydration,R63.1 - Polydipsia, **Date of Onset** :23/56/2024

Requested Investigations: 83036, HEMOGLOBIN GLYCOSYLATED A1C,9.01, Follow Up Consultation GP **Estimated Cost** :

Prescriptions: **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 : Humaira

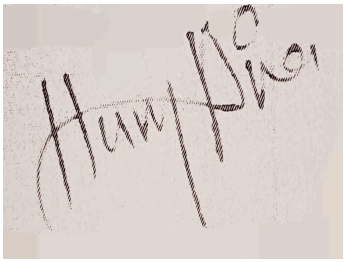
Stamp :

Dr. Humaira Mumtaz
General Practitioner
DHA No: 54155530-002
PESHAWAR MEDICAL CENTER LLC
DUBAI - U.A.E.

Patient 's signature{Parent if minor} :

Date : 23-May-2024

Signature :



Date : 23-May-2024