Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	**: Charles Navarroza Bergonio**	**Service Date**	**:27-Jun-2024**	**Network**	**:** Green
Card No	**: I017-029-116125742-02**	**Health Provider**	**:CITICARE MEDICAL CENTER LLC**	**Direct Access SP - YES**	
Policy Holder	**: Charles Navarroza Bergonio**	**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	**: 02-Apr-1984**				
Patient's Tel No	**: 0565512937**				

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 thirsty deydrated increase frequency of urination 20 may 2024 oe weak ill **Duration:** looking dehydrated oe chest is clear no added sounds stABLE

Vitals: Temp : 36.8 Bp :118 Pulse :100 Resp :18

Clinical Findings:

Diagnosis: E86.0 - Dehydration,R39.15 - Urgency of urination,E11.8 - Type 2 diabetes mellitus with unspecified complications, **Date of Onset** :27/33/2024

Requested Investigations: 9, Consultation GP,81001, URNLS DIP STICK/TABLET REAGENT AUTO MICROSCOPY,83036, HEMOGLOBIN GLYCOSYLATED A1C,83540, IRON,83550, IRON BINDING CAPACITY,82947, GLUCOSE QUANTITATIVE BLOOD XCPT REAGENT STRIP,82947, GLUCOSE QUANTITATIVE BLOOD XCPT REAGENT STRIP,83550, IRON BINDING CAPACITY,83540, IRON,83036, HEMOGLOBIN GLYCOSYLATED A1C,81001, URNLS DIP STICK/TABLET REAGENT AUTO MICROSCOPY,9, Consultation GP,83550, IRON BINDING CAPACITY,83036, HEMOGLOBIN GLYCOSYLATED A1C,82947, GLUCOSE QUANTITATIVE BLOOD XCPT REAGENT STRIP,83540, IRON,81001, URNLS DIP STICK/TABLET REAGENT AUTO MICROSCOPY,9, 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
CITICARE MEDICAL CENTER LLC
DUBAI - U.A.E.

Patient 's signature{Parent if minor} : **Date :** 27-Jun-2024

Signature : **Date** : 27-Jun-2024