Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	: **Sudesh Singh Lal Chand**	**Service Date**	:**05-Jul-2024**
Card No	: **I017-029-116125968-02**	**Health Provider**	:**CITICARE MEDICAL CENTER LLC**
Policy Holder	: **Sudesh Singh Lal Chand**	**Doctor's Name**	:**Enomen Goodluck**
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	: **12-Aug-1968**		
Patient's Tel No	: **502417416**		

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 : For routine check up. He is a known diabetic and hypercholesterolemic patient. But not hypertensive. **Duration:**

Vitals: Temp : 36.3 Bp :132 Pulse :87 Resp :18

Clinical Findings:

Diagnosis: E11.9 - Type 2 diabetes mellitus without complications,Z79.899 - Other long term (current) drug therapy, **Date of Onset** :05/43/2024

Requested Investigations: 83036, HEMOGLOBIN GLYCOSYLATED A1C,82947, GLUCOSE QUANTITATIVE BLOOD XCPT REAGENT STRIP,80061, LIPID PANEL,9, Consultation GP,9, Consultation GP,82947, GLUCOSE QUANTITATIVE BLOOD XCPT REAGENT STRIP **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 : Enomen Goodluck **Stamp :**

Dr. Enomen Goodluck Ekata
General Practitioner
DHA No: 28040827-001
CITICARE MEDICAL CENTER LLC
DUBAI - U.A.E.

Patient 's signature{Parent if minor} : **Date** : 05-Jul-2024

Signature : **Date** : 05-Jul-2024