Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	: Sudesh Singh Lal Chand	**Service Date**	:05-Jul-2024	**Network**	: Green
Card No	: I017-029-116125968-02	**Health Provider**	:CITICARE MEDICAL CENTER LLC		**Direct Access SP - YES**
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				

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 : PC: FEVER 1 DAY BODY ACHE 1 DAY VOMIT ONCE LAST DAY STOMACH PAIN, 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,R10.13 - Epigastric pain,R11.2 - Nausea with vomiting, unspecified,M54.5 - Low back pain, **Date of Onset** :05/54/2024

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,0195-107704-0802, CEFTRIAXONE-TABUK IM-(CEFTRIAXONE : 1 G) POWDER FOR INJECTION,96365, THER/PROPH/DIAG IV INF INIT,85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,86140, C REACTIVE PROTEIN **Estimated Cost** :

Prescriptions: 0139-116207-1171 - (CLAVULANIC ACID : 125 MG) (AMOXICILLIN : 500 MG) TABLETS,0005-107001-0052 - (CAFFEINE : 65 MG) (PARACETAMOL : 500 MG) CAPLETS, **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

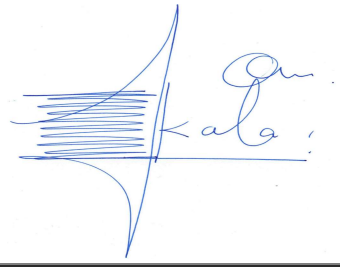
Stamp :

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