Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	: Charles Navarroza Bergonio	**Service Date**	:28-Jul-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 : labs vit d 15 hba1c is 8.4 fbs 169 co bodyache joint pain **Duration :**

Vitals: Temp : 36.75 Bp :88 Pulse :130 Resp :18

Clinical Findings:

Diagnosis: E11.9 - Type 2 diabetes mellitus without complications,E55.9 - Vitamin D deficiency, unspecified, **Date of Onset :**28/12/2024

Estimated Cost :

Requested Investigations: 9, Consultation GP

Prescriptions: 5101-640429-0061 - (VITAMIN D3 (CHOLECALCIFEROL) : 2000 IU) CAPSULES,0321-164103-0391 - (METFORMIN HCL : 500 MG) FILM COATED 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.

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

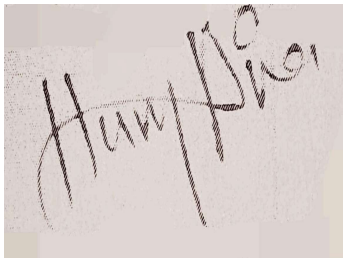
Stamp :

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

Patient 's signature{Parent if minor} :

Date : 28-Jul-2024

Signature :



Date : 28-Jul-2024