Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	**: Caleb Musyoki Nzengula**	**Service Date**	**:31-Jul-2024**
Card No	**: I017-029-116122171-02**	**Health Provider**	**:CITICARE MEDICAL CENTER LLC**
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 : come to refill the medicine metformine co dizzy restless advise fbs **Duration :**

Vitals: Temp : 37 Bp :120 Pulse :68 Resp :18

Clinical Findings:

Diagnosis: R73.9 - Hyperglycemia, unspecified,R63.1 - Polydipsia, **Date of Onset** : 31/57/2024

Requested Investigations: 9, Consultation GP,82947, GLUCOSE QUANTITATIVE BLOOD XCPT REAGENT STRIP **Estimated Cost** :

Prescriptions: 0321-164102-2191 - (METFORMIN HCL : 1000 MG) PROLONGED RELEASE 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

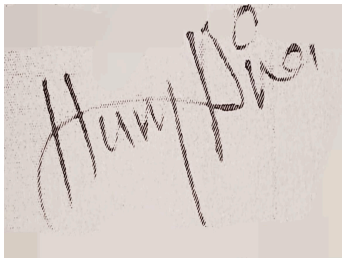
Stamp :

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

Patient 's signature{Parent if minor} :

Date : 31-Jul-2024

Signature :



Date : 31-Jul-2024