Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	: **MAJEED MASIH SARDAR MASIH**	**Service Date**	**:04-Sep-2024**	**Network**	: Green
Card No	: **I017-029-116125749-02**	**Health Provider**	**:CITICARE MEDICAL CENTER LLC**	**Direct Access SP - YES**	
Policy Holder	: **MAJEED MASIH SARDAR MASIH**	**Doctor's Name**	**:AHSAN HUSSAIN**		
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	: **03-Jan-1966**				
Patient's Tel No	: **0505140326**				

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: DIABETIC ONLY TO RE FILL MEDICATION PAIN IN SHOULDER **Duration :**

Vitals: Temp : 36.4 Bp :130 Pulse :65 Resp :18

Clinical Findings:

Diagnosis: E08.319 - Diab due to undrl cond w unsp diab rtnop w/o macular edema,M25.512 - Pain in left shoulder, **Date of Onset** :05/10/2024

Estimated Cost :

Requested Investigations: 9, Consultation GP

Prescriptions: 0788-106705-1171 - (CHLORPHENIRAMINE MALEATE : 2 MG) (PARACETAMOL : 500 MG) (PSEUDOEPHEDRINE : 30 MG) TABLETS,4417-711202-0391 - (IBUPROFEN (AS L-ARGININE SALT) : 400 MG) FILM COATED TABLETS,0090-204901-0391 - (SITAGLIPTIN (AS PHOSPHATE) : 50 MG) (METFORMIN HCL : 1000 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.

Dr's Name : AHSAN HUSSAIN **Stamp :**

Dr. Ahsan Hussain
General Practitioner
DHA No: 87543658-001
CITICARE MEDICAL CENTER LLC
DUBAI - U.A.E.

Signature :

Date : 05-Sep-2024

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.

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