Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	**: Sudesh Singh Lal Chand**	**Service Date**	**:18-Sep-2024**	**Network**	**:** Green
Card No	**: I017-029-116125968-02**	**Health Provider**	**:CITICARE MEDICAL CENTER LLC**		**Direct Access S**
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**				
Validity	**: 01-10-2023** To **30-09-2024**				
Gender	**: Male**	**Remarks**	**:**		
Date Of Birth	**: 12-Aug-1968**				
Patient's Tel No	**: 502417416**				

CONSULTATION	LAB/ RADIOLOGY	PHYSIO	PHARMACY	IP	MATEF
10% max	NIL	NIL	NIL LIMIT	NIL	10%

☐ **Acute** ☐ **Pre-existing and chronic** ☐ **Maternity**

Chief Complaints : For medication refill Has no complaint Fasting sugar and lipid profile requested. **Duration:**

Vitals: Temp : 36.1 Bp :141 Pulse :67 Resp :18

Clinical Findings:

Diagnosis: E11.65 - Type 2 diabetes mellitus with hyperglycemia,E78.2 - Mixed hyperlipidemia, **Date of Onset**

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

Prescriptions: 0114-114204-1171 - (GLIMEPIRIDE : 1 MG) TABLETS,0252-182201-0081 - (FOLIC ACID : 0.35 MG) (IRON (AS FERRIC/FERROUS HYDROXIDE POLYMALTOSE COMPLEX) : 100 MG) CHEWABLE 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 :

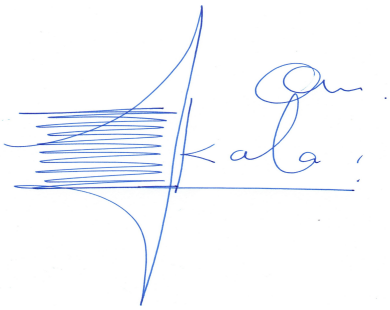
I hereby authorize any Healthcar or other organization to release a medical condition & history for p insurance benefits.

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}

Signature :  **Date** : 18-Sep-2024