Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	**: MOHAMED SALIQ CHANELIPARAMBIL ABDUL KADER**
Card No	**: I022-029-114351406-01**
Policy Holder	**: MOHAMED SALIQ CHANELIPARAMBIL ABDUL KADER**
Payer Name	**: TAKAFUL EMARAT**
TPA	**: E CARE - Blue Network**
Validity	**: 28-03-2024** To **27-03-2025**
Gender	**: Male**
Date Of Birth	**: 23-Jan-1976**
Patient's Tel No	**: 0588878445**

Service Date **:11-Dec-2024** **Network** : Green

Health Provider **:CITICARE MEDICAL CENTER LLC** **Direct Access SP - YES**

Doctor's Name **:Humaira**

Co-Insurance :

CONSULTATION	LAB/RADIOLOGY	PHYSIO	PHARMACY	IP	MATERNITY	DENTAL
10% max	NIL	NIL	NIL LIMIT	NIL	10%	NA

Remarks :

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

Chief Complaints : he is diabitic but not taking medicine he wants to check hba1c and fasting rbs now co lethargy dizzyness dehydrated 8th dec. 2024 oe chest is clear no added sounds restless **Duration:**

Vitals: Temp : 36 Bp :121 Pulse :86 Resp :18

Clinical Findings:

Diagnosis: E16.2 - Hypoglycemia, unspecified, **Date of Onset** : 11/45/2024

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

Prescriptions: **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.

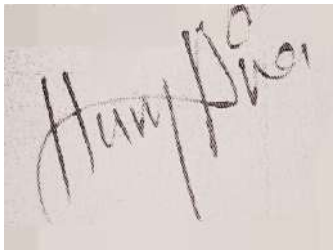
PATIENT'S DECLARATION :

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** : 11-Dec-2024

Signature :  **Date** : 11-Dec-2024