Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	: MOHAMED SALIQ CHANELIPARAMBIL ABDUL KADER	**Service Date**	:19-Dec-2024
Card No	: I022-029-114351406-01	**Health Provider**	:CITICARE MEDICAL CENTER LLC
Policy Holder	: MOHAMED SALIQ CHANELIPARAMBIL ABDUL KADER	**Doctor's Name**	:Humaira
Payer Name	: TAKAFUL EMARAT	**Co-Insurance**	:
TPA	: E CARE - Blue Network	**Remarks**	:
Validity	: 28-03-2024 To 27-03-2025		
Gender	: Male		
Date Of Birth	: 23-Jan-1976		
Patient's Tel No	: 0588878445		

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 : he is diabitic but not taking medicine he wants to check hba1c and fasting rbs now co lethargy dizzyness dehydrated 8th dec. 2024 one year before also experience this condition 15 june june 2023 then he checked his rbs at that time 290 oe chest is clear no added sounds restless **Duration:**

Vitals:

Clinical Findings:

Diagnosis: R73.9 - Hyperglycemia, unspecified,E11.8 - Type 2 diabetes mellitus with unspecified complications, **Date of Onset :**19/42/2024

Estimated Cost :

Requested Investigations: 9.01, Follow Up Consultation GP

Estimated Cost :

Prescriptions:

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.

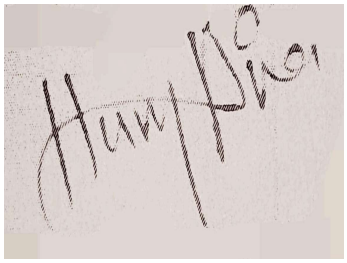
PATIENT'S DECLARATION :

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 :** 19-Dec-2024

Signature :  **Date** : 19-Dec-2024