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	**: 28-03-2025** To **27-03-2026**
Gender	**: Male**
Date Of Birth	**: 23-Jan-1976**
Patient's Tel No	**: 0588878445**

Service Date **:01-Apr-2025** **Network** : Green

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

Doctor's Name **:DR Amaizah**

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 : KNOWN DIABETIC CAME FOR BLOOD SUGAR LEVELS AND MEDICINE REFIL **Duration:**

Vitals: Temp : 36.6 Bp :113 Pulse :80 Resp :0

Clinical Findings:

Diagnosis: E08.65 - Diabetes due to underlying condition w hyperglycemia,E78.5 - Hyperlipidemia, unspecified, **Date of Onset :**01/46/2025

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

Prescriptions: 0027-188601-0391 - (VILDAGLIPTIN : 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.

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 : DR Amaizah **Stamp :**

Dr. Amaizah Ishtiaq
General Practitioner
DHA: 98486553-001
CITICARE MEDICAL CENTER
DUBAI - U.A.E

Patient 's signature{Parent if minor} : **Date :** 01-Apr-2025

Signature : **Date** : 01-Apr-2025