Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	: **GIAN CARLO DE GUZMAN BENITEZ**	**Service Date**	:**21-Apr-2025** **Network** : Green
Card No	: **I011-029-113219002-01**	**Health Provider**	:**CITICARE MEDICAL CENTER LLC** **Direct Access SP - YES**
Policy Holder	: **GIAN CARLO DE GUZMAN BENITEZ**	**Doctor's Name**	:**DR Amaizah**
Payer Name	: **AL SAGR NATIONAL INSURANCE COMPANY**	**Co-Insurance**	:
TPA	: **E CARE - Green Network**	**Remarks**	:
Validity	: **13-12-2024** To **12-12-2025**		
Gender	: **Male**		
Date Of Birth	: **16-Jun-1985**		
Patient's Tel No	: **0588961685**		

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 : known diabetese , known hyperlipidemia came with high blood pressure and numbness in both arms o/e : look pale , lethargic high blood pressure **Duration:**

Vitals: Temp : 36.1 Bp :146 Pulse :84 Resp :18

Clinical Findings:

Diagnosis: I10 - Essential (primary) hypertension,E11.65 - Type 2 diabetes mellitus with hyperglycemia,E78.2 - Mixed hyperlipidemia, **Date of Onset** :21/49/2025

Estimated Cost :

Requested Investigations: 9, Consultation GP

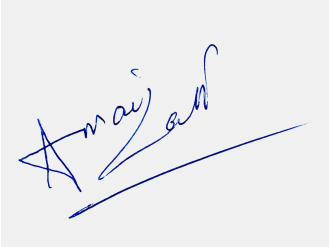
Prescriptions: 0090-205002-0391 - (SITAGLIPTIN (AS PHOSPHATE) : 50 MG) FILM COATED TABLETS,2150-575201-1171 - (CALCIUM : 400 MG) (VITAMIN D3 : 200 IU) (MAGNESIUM : 100 MG) (ZINC : 4 MG) TABLETS,2104-379202-1451 - (AMLODIPINE (AS BESYLATE) : 10 MG) CAPSULES (HARD GELATIN),0188-155602-0391 - (ROSUVASTATIN (AS CALCIUM) : 10 MG) FILM COATED TABLETS,0188-585204-0361 - (DAPAGLIFLOZIN (AS PROPANEDIOL) : 10 MG) (METFORMIN HCL : 1000 MG) EXTENDED RELEASE 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 : DR Amaizah **Stamp :**

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

Signature :  **Date** : 21-Apr-2025

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 :** 21-Apr-2025