Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	: **OTHMANE FILALI BABA**	**Service Date**	:**05-May-2025** **Network** : Green
Card No	: **I022-029-120377738-01**	**Health Provider**	:**CITICARE MEDICAL CENTER LLC** **Direct Access SP - YES**
Policy Holder	: **OTHMANE FILALI BABA**	**Doctor's Name**	:**Dr.Farhan Iyas**
Payer Name	: **TAKAFUL EMARAT**		
TPA	: **E CARE - Green Network**	**Co-Insurance**	:
Validity	: **11-11-2024** To **10-11-2025**	**Remarks**	:
Gender	: **Male**		
Date Of Birth	: **24-Apr-1992**		
Patient's Tel No	: **0503820364**		

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 : polyuria polydipsia a little weight loss **Duration :**

Vitals: Temp : 36.1 Bp :124 Pulse :84 Resp :18

Clinical Findings:

Diagnosis: E11.65 - Type 2 diabetes mellitus with hyperglycemia, **Date of Onset** : 05/19/2025

Requested Investigations: 001032, Random Blood Suger (RBS),83036, HBA1C, BLOOD,83036, HEMOGLOBIN GLYCOSYLATED A1C,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.

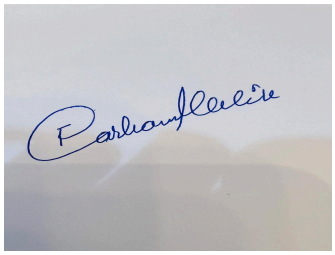
PATIENT'S DECLARATION :

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 : Dr.Farhan Iyas **Stamp :**

Dr .Frahan Ilyas Malik
Physician-General Practitioner
DHA-06441782-001
CITICARE MEDICAL CENTER
DUBAI U.A.E

Patient 's signature{Parent if minor} : **Date :** 05-May-2025

Signature :  **Date** : 05-May-2025