## 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-Jun-2025** **Network** : Green

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

**Doctor's Name** **:AISHA**

**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 : 36.5 Bp :124 Pulse :83 Resp :18

**Clinical Findings:**

**Diagnosis:** E11.8 - Type 2 diabetes mellitus with unspecified complications,R73.9 - Hyperglycemia, unspecified,E78.49 - Other hyperlipidemia,I10 - Essential (primary) hypertension,R80.0 - Isolated proteinuria, **Date of Onset** :01/24/2025

**Requested Investigations:** 83036, HEMOGLOBIN GLYCOSYLATED A1C,82947, GLUCOSE QUANTITATIVE BLOOD XCPT REAGENT STRIP,80061, LIPID PANEL,80069, RENAL FUNCTION PANEL,81003, URNLS DIP STICK TABLET RGNT AUTO WO MICROSCOPY,9, Consultation GP **Estimated Cost** :

**Prescriptions:** 0027-188601-0391 - (VILDAGLIPTIN : 50 MG) (METFORMIN HCL : 1000 MG) FILM COATED TABLETS, **Estimated Cost** :

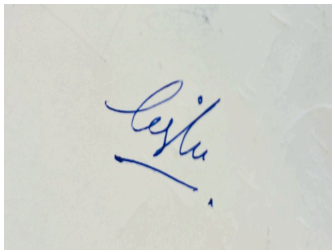
**MEDICAL PRACTITIONER DECLARATION :**

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.

**Dr's Name** : AISHA

**Stamp :**

Dr. Aisha Umer
Physician- General Practitioner
DHA- 40131439-002
CITICARE MEDICAL CENTER
DUBAI - U.A.E

**Signature :** 

**Date** : 01-Jun-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 :** 01-Jun-2025