Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	: **RAMI SAMIR KAMAL ABDELAZIZ**	**Service Date**	**:01-Jul-2025** **Network** : Green
Card No	: **I040-029-122697383-01**	**Health Provider**	**:CITICARE MEDICAL CENTER LLC** **Direct Access SP - YES**
Policy Holder	: **RAMI SAMIR KAMAL ABDELAZIZ**	**Doctor's Name**	**:SANDIA**
Payer Name	: **UNION INSURANCE COMPANY**		
TPA	: **E CARE - Green Network**		
Validity	: **01-10-2024** To **30-09-2025**	**Remarks**	:
Gender	: **Male**		
Date Of Birth	: **22-Jan-1985**		
Patient's Tel No	: **0527640808**		

Co-Insurance :

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 : diabtes mellitus taking insulin since 1 year pt is here for medication refill **Duration :**

Vitals: Temp : 36.6 Bp :120 Pulse :68 Resp :18

Clinical Findings:

Diagnosis: E08.65 - Diabetes due to underlying condition w hyperglycemia,I10 - Essential (primary) hypertension, **Date of Onset:**01/16/2025

Estimated Cost :

Requested Investigations: 9, Consultation GP

Prescriptions: 1290-640418-1171 - (VITAMIN D3 (CHOLECALCIFEROL) : 1000 IU) TABLETS,0043-235201-1021 - (INSULIN ASPART : 100 IU/ML) SOLUTION FOR INJECTION,0043-508401-1021 - (INSULIN DEGLUDEC : 100 U/ML) SOLUTION FOR INJECTION,1394-807702-1171 - (OLMESARTAN MEDOXOMIL : 40 MG) (AMLODIPINE (AS BESYLATE) : 5 MG) (HYDROCHLOROTHIAZIDE : 12.5 MG) TABLETS,

Estimated Cost :

MEDICAL PRACTITIONER DECLARATION :

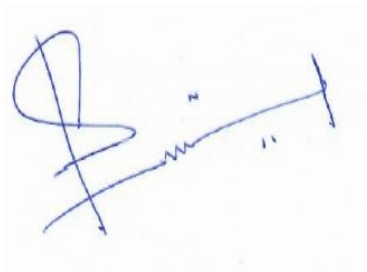
I declare that I am the patient's medical practitioner and that the particulars given are to the best of my knowledge true and correct.

Dr's Name : SANDIA

Stamp :

Dr. Sandia Bhojwani
General Practitioner
DHA No: 65900212-001
PESHAWAR MEDICAL CENTER LLC
DUBAI - U.A.E.

Signature :



Date : 01-Jul-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-Jul-2025