Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	: **JOSE RAFAEL LOPERA EVANGELISTA**	**Service Date**	**:19-Feb-2024**
Card No	: **I017-029-116122138-02**	**Health Provider**	**:Irham Medical Center Arjan**
Policy Holder	: **JOSE RAFAEL LOPERA EVANGELISTA**	**Doctor's Name**	**:Sajid Sanaullah**
Payer Name	: **ABU DHABI NATIONAL INSURANCE COMPANY-ADNIC**	**Co-Insurance**	:
TPA	: **E CARE - Green Network**	**Remarks**	:
Validity	: **01-10-2023** To **30-09-2024**		
Gender	: **Male**		
Date Of Birth	: **19-Mar-1977**		
Patient's Tel No	: **0563597129**		

Network : Green

Direct Access SP - YES

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 : KNOWN DIABETIC SINCE 1 YEAR ALREADY TAKING MEDICATION AND CONTROLLED SUGAR LEVELS ON METFORMIN **Duration:**

Vitals: Temp : 36.2 Bp :135 Pulse :87 Resp :22

Clinical Findings:

Diagnosis: E11.9 - Type 2 diabetes mellitus without complications, **Date of Onset** : 19/44/2024

Requested Investigations: 9, Consultation GP **Estimated Cost** :

Prescriptions: 0090-204901-0391 - (SITAGLIPTIN (AS PHOSPHATE) : 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 : Sajid Sanaullah

Stamp :

Patient 's signature{Parent : if minor}

Date : 19-Feb-2024

Signature :

Date : 19-Feb-2024