Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	: **LIEZEL SUICO DESABILLE**	**Service Date**	:**16-May-2024**
Card No	: **I040-029-113719145-01**	**Health Provider**	:**Irham Medical Center Arjan**
Policy Holder	: **LIEZEL SUICO DESABILLE**	**Doctor's Name**	:**Enomen Goodluck**
Payer Name	: **UNION INSURANCE COMPANY**	**Co-Insurance**	
TPA	: **E CARE - Blue Network**		
Validity	: **02-01-2024** To **01-01-2025**	**Remarks**	:
Gender	: **Female**		
Date Of Birth	: **19-Oct-1974**		
Patient's Tel No	: **0567312820**		

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 : C/o: For medication refill. A known hypertensive on Telmisartan. **Duration :**

Vitals: Temp : 36.7 Bp :134 Pulse :74 Resp :18

Clinical Findings:

Diagnosis: I10 - Essential (primary) hypertension,Z76.0 - Encounter for issue of repeat prescription,Z79.899 - Other long term (current) drug therapy, **Date of Onset** :16/27/2024

Estimated Cost :

Requested Investigations: 9, Consultation GP

Prescriptions: 0013-186702-0391 - (LOSARTAN POTASSIUM : 50 MG) (HYDROCHLOROTHIAZIDE : 12.5 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 : Enomen Goodluck

Stamp :

Dr. Enomen Goodluck Ekata
General Practitioner
DHA No: 28040827-001
PESHAWAR MEDICAL CENTER LLC
DUBAI : U.A.E.

Patient 's signature{Parent if minor} :

Date : 16-May-2024

Signature :

Date : 16-May-2024