Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	**: TEBOGO RUTH MOTAU**
Card No	**: I040-029-120319774-01**
Policy Holder	**: TEBOGO RUTH MOTAU**
Payer Name	**: UNION INSURANCE COMPANY**
TPA	**: E CARE - Blue Network**
Validity	**: 15-01-2024** To **14-01-2025**
Gender	**: Female**
Date Of Birth	**: 27-Nov-1997**
Patient's Tel No	**: 0551542093**

Service Date :16-Sep-2024 **Network** : Green

Health Provider :CITICARE MEDICAL CENTER LLC **Direct Access SF**

Doctor's Name :Enomen Goodluck

Co-Insurance :

CONSULTATION	LAB/ RADIOLOGY	PHYSIO	PHARMACY	IP	MATEF
10% max	NIL	NIL	NIL LIMIT	NIL	10%

Remarks :

☐ **Acute** ☐ **Pre-existing and chronic** ☐ **Maternity**

Chief Complaints : Bleeding per vaginam, dizziness, and weakness Duration: 10days, Recently had a missed abortion and was being managed by the gynaecologist. now has dizziness, thus necessitating her presentation. HB is 8 iron studies are low. Iron transfusion is advised. **Duration:**

Vitals: Temp : 37.2 Bp :116 Pulse :88 Resp :18

Clinical Findings:

Diagnosis: D50.0 - Iron deficiency anemia secondary to blood loss (chronic),E61.1 - Iron deficiency,R42 - Dizziness and giddiness,R53.1 - Weakness, **Date of Onset**

Estimated Cost :

Requested Investigations: 9, Consultation GP

Estimated Cost :

Prescriptions:

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 :

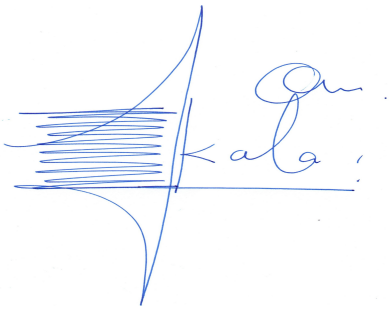
I hereby authorize any Healthcar or other organization to release a medical condition & history for p insurance benefits.

Dr's Name : Enomen Goodluck

Stamp :

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

Patient 's signature{Parent : if minor}

Signature :  **Date** : 16-Sep-2024