Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	**: LIEZEL SUICO DESABILLE**
Card No	**: I040-029-113719145-01**
Policy Holder	**: LIEZEL SUICO DESABILLE**
Payer Name	**: UNION INSURANCE COMPANY**
TPA	**: E CARE - Blue Network**
Validity	**: 02-01-2024** To **01-01-2025**
Gender	**: Female**
Date Of Birth	**: 19-Oct-1974**
Patient's Tel No	**: 0567312820**

Service Date :18-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 : For medication refill. has nil complaint. Has not taking medication for the past 3days. **Duration:**

Vitals: Temp : 36.6 Bp :174 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,E78.5 - Hyperlipidemia, unspecified, **Date of Onset**

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 :

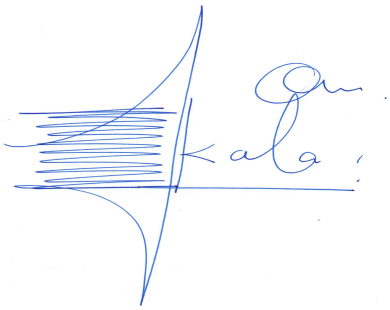
I hereby authorize any Healthcar or other organization to release a medical condition & history for p insurance benefits.

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** : 18-Sep-2024