

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 : 02-01-2025 To 01-01-2026
Gender : Female
Date Of Birth : 19-Oct-1974
Patient's Tel No : 0563093585

Service Date :15-Jan-2025
Health Provider :CITICARE MEDICAL CENTER LLC
Doctor's Name :Enomen Goodluck

Network : Green
Direct Access SP - YES

Co-Insurance :

CONSULTATION	LAB/RADIOLOGY	PHYSIO	PHARMACY	IP	MATERNITY	DENTAL
10% max	NIL	NIL	NIL LIMIT	NIL	10%	NA

Remarks :

☐ Acute☐ Pre-existing and chronic☐ Maternity

Chief Complaints : complain of dry cough,sore throat,bodyache,headache. o/e chest congestion,redness in thorat previously taking medication for hypertension

Duration:

Vitals:Temp : 36.7 Bp :114 Pulse :73 Resp :18

Clinical Findings:

Diagnosis: J02.9 - Acute pharyngitis, unspecified,R50.9 - Fever, unspecified,R52 - Pain, unspecified,

Date of Onset :15/08/2025

Estimated Cost :

Requested Investigations: 9, Consultation GP

Prescriptions: 0397-116213-0801 - (CLAVULANIC ACID : 100 MG (AMOXICILLIN : 500 MG POWDER FOR INJECTION,0006-106601-0392 - (PARACETAMOL : 500 MG) FILM COATED TABLETS,0320-148701-1171 - Cost (LORATADINE : 10 MG) TABLETS,1516-446701-1161 - (SODIUM CITRATE : 57 MG/5ML (AMMONIUM CHLORIDE : 131.5 MG/5 ML (MENTHOL : 1.1 MG/5 ML (DIPHENHYDRAMINE HCL : 13.5 MG/5ML SYRUP,

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 :

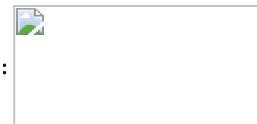
I hereby authorize any Healthcare provider, Insurer, Employer or other organization to release any information regarding my medical condition & history for purpose of determining insurance benefits.

Dr's Name : Enomen Goodluck

Stamp :



Patient 's signature{Parent : if minor}



Date : Jan-2025

Signature :

Date : 15-Jan-2025