## Administrative

## MEDICAL CLAIM FORM

## Claim Ref:

| | | | | | |
|---|---|---|---|---|---|
| **Patient Name** | : LIEZEL SUICO DESABILLE | **Service Date** | :15-Jan-2025 | **Network** | : Green |
| **Card No** | : I040-029-113719145-01 | **Health Provider** | :CITICARE MEDICAL CENTER LLC | | **Direct Access SP - YES** |
| **Policy Holder** | : LIEZEL SUICO DESABILLE | **Doctor's Name** | :Enomen Goodluck | | |
| **Payer Name** | : UNION INSURANCE COMPANY | **Co-Insurance** | : | | |
| **TPA** | : E CARE - Blue Network | **Remarks** | : | | |
| **Validity** | : 02-01-2025 To 01-01-2026 | | | | |
| **Gender** | : Female | | | | |
| **Date Of Birth** | : 19-Oct-1974 | | | | |
| **Patient's Tel No** | : 0563093585 | | | | |

| 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 :** complain of dry cough,sore throat,bodyache,headache. o/e chest congesion,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 - (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, **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
CITICARE MEDICAL CENTER LLC
DUBAI - U.A.E.

**Patient 's signature{Parent if minor}** : **Date :** 15-Jan-2025

**Signature :** **Date** : 15-Jan-2025