Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	**: LIEZEL SUICO DESABILLE**	**Service Date**	**:19-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**	**:Humaira**
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	**: 0567312820**		

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 : For medication refill. has nil complaint. **Duration :**

Vitals: Temp : 36.6 Bp :160 Pulse :78 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** :20/03/2025

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 : Humaira

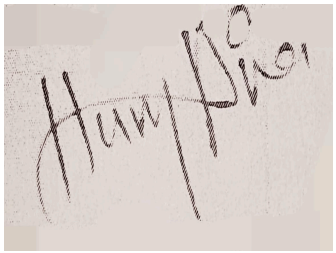
Stamp :

Dr. Humaira Mumtaz
General Practitioner
DHA No: 54155530-002
CITICARE MEDICAL CENTER LLC
DUBAI - U.A.E.

Patient 's signature{Parent if minor} :

Date : 20-Jan-2025

Signature :



Date : 20-Jan-2025