Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	**: LIEZEL SUICO DESABILLE**	**Service Date**	**:17-Feb-2025**
Card No	**: I040-029-113719145-01**	**Network**	: Green
Policy Holder	**: LIEZEL SUICO DESABILLE**	**Health Provider**	**:CITICARE MEDICAL CENTER LLC**
Payer Name	**: UNION INSURANCE COMPANY**		**Direct Access SP - YES**
TPA	**: E CARE - Blue Network**	**Doctor's Name**	**:Humaira**
Validity	**: 02-01-2025** To **01-01-2026**	**Remarks**	:
Gender	**: Female**		
Date Of Birth	**: 19-Oct-1974**		
Patient's Tel No	**: 0567312820**		

Co-Insurance :

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 : patient came with dry cough and dizziness she is a known case of hypertension and asthma allergic to dust **Duration:**

Vitals: Temp : 37 Bp :143 Pulse :78 Resp :18

Clinical Findings:

Diagnosis: I10 - Essential (primary) hypertension,R05 - Cough,R50.9 - Fever, unspecified,M79.10 - Myalgia, unspecified site, **Date of Onset** :17/23/2025

Requested Investigations: 0188-135906-2441, PULMICORT-(BUDESONIDE : 0.5 MG/ML) SUSPENSION FOR NEBULIZATION,94640, AIRWAY INHALATION TREATMENT,9, Consultation GP **Estimated Cost :**

Prescriptions: 0788-106705-1171 - (CHLORPHENIRAMINE MALEATE : 2 MG) (PARACETAMOL : 500 MG) (PSEUDOEPHEDRINE : 30 MG) TABLETS,0005-116702-2481 - (DIPHENHYDRAMINE : 12.5 MG/5ML) SYRUP (SUGAR FREE),0097-127405-0391 - (AZITHROMYCIN : 500 MG FILM COATED TABLETS,6666-186702-1171 - (LOSARTAN POTASSIUM : 50 MG (HYDROCHLOROTHIAZIDE : 12.5 MG TABLETS, **Estimated Cost :**

MEDICAL PRACTITIONER DECLARATION :

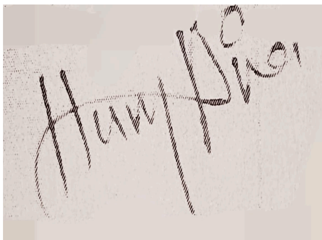
I declare that I am the patient's medical practitioner and that the particulars given are to the best of my knowledge true and correct.

Dr's Name : Humaira

Stamp :

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

Signature :



Date : 17-Feb-2025

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.

Patient 's signature{Parent if minor} :

Date : 17-Feb-2025