Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	: **Maureen Ancheta Kahulugan**	**Service Date**	:**03-Apr-2025**
Card No	: **I040-029-113718844-01**	**Health Provider**	:**CITICARE MEDICAL CENTER LLC**
Policy Holder	: **Maureen Ancheta Kahulugan**	**Doctor's Name**	:**DR Amaizah**
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	: **13-Nov-1978**		
Patient's Tel No	: **0544316073**		

Network : Green

Direct Access SP - YES

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 : PC : SEVERE HEADACHE , DIZZINESS , ASSOCIATED WITH NAUSEA AND VOMITTING STARTED 01/04/25 SEVERE 8 ON PAIN SCALE BP IS ELEVATED **Duration:**

Vitals: Temp : 36.8 Bp :180 Pulse :78 Resp :22

Clinical Findings:

Diagnosis: R52 - Pain, unspecified,R51.9 - Headache, unspecified,R03.0 - Elevated blood-pressure reading, w/o diagnosis of htn, **Date of Onset** :03/52/2025

Requested Investigations: 0005-149902-1021, CLOFEN ,2190-106618-1001, PARAFUSIV,0005-150403-1021, PREMOSAN -(METOCLOPRAMIDE : 10 MG/2ML) SOLUTION FOR INJECTION,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE,96372, THER/PROPH/DIAG INJ SC/IM,9, Consultation GP,96365, THER/PROPH/DIAG IV INF INIT **Estimated Cost** :

Prescriptions: 0027-142201-0832 - (DICLOFENAC POTASSIUM : 50 MG) POWDER FOR SOLUTION,0186-143701-0062 - (CELECOXIB : 200 MG) CAPSULES, **Estimated Cost** :

MEDICAL PRACTITIONER DECLARATION :

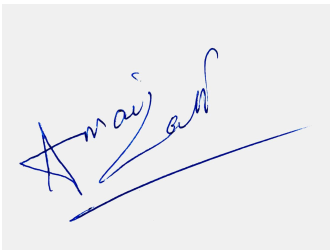
I declare that I am the patient's medical practitioner and that the particulars given are to the best of my knowledge true and correct.

Dr's Name : DR Amaizah

Stamp :

Dr. Amaizah Ishtiaq
General Practitioner
DHA: 98486553-001
CITICARE MEDICAL CENTER
DUBAI - U.A.E

Signature :



Date : 03-Apr-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 : 03-Apr-2025