Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	: **Maureen Ancheta Kahulugan**	**Service Date**	**:09-May-2025**
Card No	: **I040-029-113718844-01**	**Health Provider**	**:CITICARE MEDICAL CENTER LLC**
Policy Holder	: **Maureen Ancheta Kahulugan**	**Doctor's Name**	**:AISHA**
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 : pt came with low back pain along with dark urine for the last 4 days **Duration :**

Vitals: Temp : 37 Bp :148 Pulse :89 Resp :18

Clinical Findings:

Diagnosis: N39.0 - Urinary tract infection, site not specified,M54.5 - Low back pain,R30.0 - Dysuria,R52 - Pain, unspecified,E86.0 - Dehydration, **Date of Onset** :09/39/2025

Requested Investigations: 86140, C REACTIVE PROTEIN,80069, RENAL FUNCTION PANEL,0005-149902-1021, CLOFEN -(DICLOFENAC SODIUM : 75 MG/3ML) SOLUTION FOR INJECTION,0005-136504-1021, SCOPINAL,0102-100104-1001, SODIUM CHLORIDE & DEXTROSE B.P.,96372, THER/PROPH/DIAG INJ SC/IM,96365, THER/PROPH/DIAG IV INF INIT,9, Consultation GP **Estimated Cost** :

Prescriptions: 5254-830602-2401 - (VITAMIN B1 (THIAMINE) : 100 MG) (VITAMIN B6 (AS PYRIDOXINE HCL) : 200 MG) (VITAMIN B12 (CYANOCOBALAMIN) : 200 MCG) SUGAR COATED TABLETS,2093-596002-0431 - (DICLOFENAC DIETHYLAMINE : 23.2 MG / G) GEL,0027-149904-0341 - (DICLOFENAC SODIUM : 50 MG) ENTERIC COATED TABLETS,6619-548302-0251 - (SODIUM BICARBONATE : 1.76G) (SODIUM CITRATE ANHYDROUS : 0.63G) (TARTARIC ACID : 0.89G) (CITRIC ACID ANHYDROUS : 0.715 G) EFFERVESCENT GRANULES, **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 : AISHA

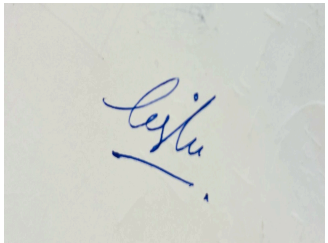
Stamp :

Dr. Aisha Umer
Physician- General Practitioner
DHA- 40131439-002
CITICARE MEDICAL CENTER
DUBAI - U.A.E

Patient 's signature{Parent if minor} :

Date : 09-May-2025

Signature :



Date : 09-May-2025