Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	**: LIEZEL SUICO DESABILLE**
Card No	**: I040-029-113719145-01**
Policy Holder	**: LIEZEL SUICO DESABILLE**
Payer Name	**: UNION INSURANCE COMPANY**
TPA	**: E CARE - Blue Network**
Validity	**: 02-01-2025** To **01-01-2026**
Gender	**: Female**
Date Of Birth	**: 19-Oct-1974**
Patient's Tel No	**: 0563093585**

Service Date **:14-May-2025** **Network** : Green

Health Provider **:CITICARE MEDICAL CENTER LLC** **Direct Access SP - YES**

Doctor's Name **:DR Amaizah**

Co-Insurance :

CONSULTATION	LAB/RADIOLOGY	PHYSIO	PHARMACY	IP	MATERNITY	DENTAL
10% max	NIL	NIL	NIL LIMIT	NIL	10%	NA

Remarks :

☐ **Acute** ☐ **Pre-existing and chronic** ☐ **Maternity**

Chief Complaints : k/c/o htn for refill of medication **Duration** :

Vitals: Temp : 36.8 Bp :140 Pulse :73 Resp :18

Clinical Findings:

Diagnosis: I10 - Essential (primary) hypertension,R07.9 - Chest pain, unspecified, **Date of Onset** :14/24/2025

Estimated Cost :

Requested Investigations: 9, Consultation GP

Prescriptions: 0252-186702-0391 - (LOSARTAN POTASSIUM : 50 MG) (HYDROCHLOROTHIAZIDE : 12.5 MG) FILM COATED TABLETS,

Estimated Cost :

MEDICAL PRACTITIONER DECLARATION :

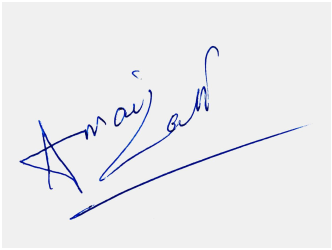
I declare that I am the patient's medical practitioner and that the particulars given are to the best of my knowledge true and correct.

Dr's Name : DR Amaizah

Stamp :

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

Signature :



Date : 14-May-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 : 14-May-2025