Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	: **Pedro Vergara Mangantulao**	**Service Date**	:**04-Jun-2025**
Card No	: **I040-029-117330364-01**	**Health Provider**	:**CITICARE MEDICAL CENTER LLC**
Policy Holder	: **Pedro Vergara Mangantulao**	**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	: **Male**		
Date Of Birth	: **03-Nov-1974**		
Patient's Tel No	: **0523691302**		

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 : CAME FOR REGULAR SCREENING OF DIABTESE AND HYPERLIPIDEMA FAMILY HX OF HTN **Duration:**

Vitals: Temp : 37 Bp :124 Pulse :84 Resp :18

Clinical Findings:

Diagnosis: E11.65 - Type 2 diabetes mellitus with hyperglycemia,E78.2 - Mixed hyperlipidemia,E66.9 - Obesity, unspecified, **Date of Onset** :04/33/2025

Requested Investigations: 80061, LIPID PANEL,82947, GLUCOSE QUANTITATIVE BLOOD XCPT REAGENT STRIP,83036, HEMOGLOBIN GLYCOSYLATED A1C,9, Consultation GP **Estimated Cost** :

Prescriptions: **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** : 04-Jun-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 :** 04-Jun-2025