Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	**: TEBOGO RUTH MOTAU**
Card No	**: I040-029-120319774-01**
Policy Holder	**: TEBOGO RUTH MOTAU**
Payer Name	**: UNION INSURANCE COMPANY**
TPA	**: E CARE - Blue Network**
Validity	**: 05-02-2025** To **04-02-2026**
Gender	**: Female**
Date Of Birth	**: 27-Nov-1997**
Patient's Tel No	**: 0551542093**

Service Date **:08-Jul-2025** **Network** **:** Green

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

Doctor's Name **:AISHA**

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 : pc : weakness ,body pain hopc : pt came with loss of appetide along with weakness and vertigo for the last one month history of iron deficiency anemia hypercholesterolemia she is not taking any oral medication **Duration:**

Vitals: Temp : 36.8 Bp :140 Pulse :88 Resp :18

Clinical Findings:

Diagnosis: E78.00 - Pure hypercholesterolemia, unspecified,I10 - Essential (primary) hypertension,R73.9 - Hyperglycemia, unspecified,D50.9 - Iron deficiency anemia, unspecified,R42 - Dizziness and giddiness,R30.0 - Dysuria,R63.0 - Anorexia, **Date of Onset** **:**08/44/2025

Requested Investigations: 85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,80061, LIPID PANEL,82947, GLUCOSE QUANTITATIVE BLOOD XCPT REAGENT STRIP,81003, URNLS DIP STICK TABLET RGNT AUTO WO MICROSCOPY,97010, SPECIAL SUPPLIES,99070, SPECIAL SUPPLIES,9, Consultation GP **Estimated Cost** **:**

Prescriptions: 1796-537201-0991 - (GLUTODINE : 3 MG/10ML) (ARGININE ASPARTATE : 1000 MG/10ML) SOLUTION,6506-931301-1451 - (ZINC GLUCONATE : 97.58 MG) (IRON (FERROUS FUMARATE) : 76.07 MG) (VITAMIN B6 (AS PYRIDOXINE HCL) : 6.07 MG) (CUPRIC CITRATE (COPPER) : 5.68 MG) (VITAMIN B12 (CYANOCOBALAMIN) : 1 MG) (PTEROYLMONOGLUTAMIC ACID : 500 MCG) CAPSULES (HARD GELATIN), **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

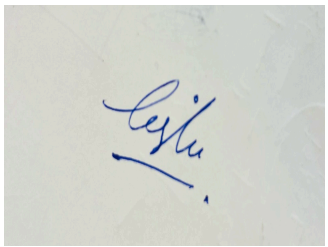
Stamp :

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

Patient 's signature{Parent if minor} **:**

Date : 08-Jul-2025

Signature :



Date **:** 08-Jul-2025