Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	: **MARVIN MOLINA JOSE**	**Service Date**	:**01-Aug-2025** **Network** : Green
Card No	: **I040-029-113718524-01**	**Health Provider**	:**CITICARE MEDICAL CENTER LLC** **Direct Access SP - YES**
Policy Holder	: **MARVIN MOLINA JOSE**	**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	: **13-Nov-1978**		
Patient's Tel No	: **0521094471**		

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 : **Duration :**

Vitals: Temp : 36.6 Bp :160 Pulse :70 Resp :18

Clinical Findings:

Diagnosis: I10 - Essential (primary) hypertension, **Date of Onset** : 02/08/2025

Requested Investigations: 9, Consultation GP **Estimated Cost :**

Prescriptions: 6696-627102-1171 - (VALSARTAN : 160 MG) (AMLODIPINE (AS BESYLATE) : 10 MG) 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** : 02-Aug-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 :** 02-Aug-2025