Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	: **LIEZEL SUICO DESABILLE**	**Service Date**	:**02-Aug-2025** **Network** : Green
Card No	: **I040-029-113719145-01**	**Health Provider**	:**CITICARE MEDICAL CENTER LLC** **Direct Access SP - YES**
Policy Holder	: **LIEZEL SUICO DESABILLE**	**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	: **Female**		
Date Of Birth	: **19-Oct-1974**		
Patient's Tel No	: **0567312820**		

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 : came for medication refill known hypertensive pc : dry cough and low back pain **Duration:**

Vitals: Temp : 36 Bp :130 Pulse :78 Resp :18

Clinical Findings:

Diagnosis: I10 - Essential (primary) hypertension,R05 - Cough,M54.5 - Low back pain, **Date of Onset** :02/57/2025

Estimated Cost :

Requested Investigations: 9, Consultation GP

Prescriptions: 0027-265802-1161 - (BUTAMIRATE DIHYDROGEN CITRATE : 0.15% W/V) SYRUP,3819-373201-0391 - (TOLPERISONE HCL : 150 MG) FILM COATED TABLETS,0252-186702-0391 - (LOSARTAN POTASSIUM : 50 MG) (HYDROCHLOROTHIAZIDE : 12.5 MG) FILM COATED TABLETS, **Estimated Cost** :

MEDICAL PRACTITIONER DECLARATION :

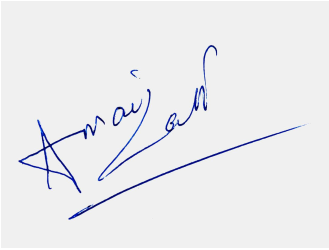
I declare that I am the patient's medical practitioner and that the particulars given are to the best of my knowledge true and correct.

Dr's Name : DR Amaizah

Stamp :

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

Signature :



Date : 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