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 :**19-Aug-2025** **Network** : Green

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

Doctor's Name :**KEERTHANA**

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 tiredness,headache,dizziness,tremor HOPC pt complaints oftiredness,headache,dizziness,tremor since 2 days She is having bleeding per vagina post abortion She is going back to home tonight for gynecology consulation She gaves the history of molar pregnancy in september 2024 O\E looks pale and dehydrated LMP june 2025 history of iron deficiency anemia Advised gynecology followup **Duration:**

Vitals: Temp : 36.2 Bp :120 Pulse :80 Resp :18

Clinical Findings:

Diagnosis: D50.9 - Iron deficiency anemia, unspecified,R53.1 - Weakness,R11.2 - Nausea with vomiting, unspecified,R42 - Dizziness and giddiness, **Date of Onset** :19/55/2025

Requested Investigations: 0439-152905-1001, LACTATED RINGERS INJECTION USP,97010, SPECIAL SUPPLIES,0005-150403-1021, PREMOSAN ,9, Consultation GP,96360, HYDRATION IV INFUSION INIT,96372, THER/PROPH/DIAG INJ SC/IM **Estimated Cost** :

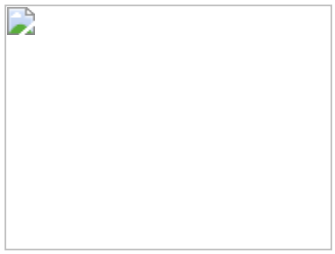
Prescriptions: **Estimated Cost** :

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 : KEERTHANA **Stamp :**

د. كيرثانا راني بادييورايل ثارا
Dr. Keerthana Rani Padippurayil Thara
General Practitioner
License No.: 37864046-001
مـركـز سيتيكير الطبي ذ م م
CITICARE MEDICAL CENTER LLC

Signature :  **Date** : 19-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 :** 19-Aug-2025