Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	**: NAW NOBLE STAR**
Card No	**: I040-029-120585625-01**
Policy Holder	**: NAW NOBLE STAR**
Payer Name	**: UNION INSURANCE COMPANY**
TPA	**: E CARE - Blue Network**
Validity	**: 02-01-2024** To **01-01-2025**
Gender	**: Female**
Date Of Birth	**: 22-Oct-1992**
Patient's Tel No	**: 0555635483**

Service Date **:12-Aug-2024** **Network** **:** Green

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

Doctor's Name **:AHSAN HUSSAIN**

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: DIARRHEA VOMITING EPIGASTRIC PAIN WEAKNESS **Duration :**

Vitals: Temp : 36.8 Bp :102 Pulse :78 Resp :18

Clinical Findings:

Diagnosis: K29.00 - Acute gastritis without bleeding,R11.2 - Nausea with vomiting, unspecified,R19.7 - Diarrhea, unspecified,R10.13 - Epigastric pain, **Date of Onset** :12/25/2024

Requested Investigations: 9, Consultation GP,0005-150403-1021, PREMOSAN -(METOCLOPRAMIDE : 10 MG/2ML) SOLUTION FOR INJECTION,0005-136504-1021, SCOPINAL,0005-107704-0802, TRIAXONE I.V.-(CEFTRIAXONE : 1 G) POWDER FOR INJECTION,96365, THER/PROPH/DIAG IV INF INIT,96372, THER/PROPH/DIAG INJ SC/IM **Estimated Cost :**

Prescriptions: 6187-925001-2471 - (TULSI (OCIMUM SANCTUM) : 100 MG/10ML) (ADHATODA VASICA : 100 MG/10ML) (VIOLA ODORATA : 75 MG/10ML) (CURCUMA LONGA : 25MG/10ML) (ELETTARIA CARDAMOMUM : 25MG/10ML) (GLYCYRRHIZA GLABRA : 100 MG/10ML) (SOLANUM XANTHOCARPUM : 75 MG/10ML) (PIPER LONGUM : 25MG/10ML) (ZINGIBER OFFICINALE : 50MG/10ML) (DALCHINI : 10 MG/10ML) (SYZYGIUM AROMATICUM : 10 MG/10ML) SYRUP (ALCOHOL FREE),5849-230503-4021 - (DEXTROSE ANHYDROUS : 20 G) (SODIUM CHLORIDE : 3.5 G) (POTASSIUM CHLORIDE : 1.5 G) (SODIUM CITRATE : 2.9 G) POWDER FOR ORAL SOLUTION,0252-150407-1171 - (METOCLOPRAMIDE : 10 MG) TABLETS,0152-116604-0391 - (METRONIDAZOLE : 500 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.

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.

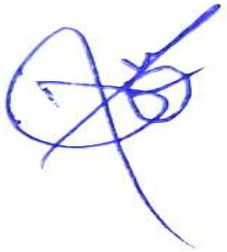
Dr's Name : AHSAN HUSSAIN

Stamp :

Patient 's signature{Parent : if minor}

Date : 12-Aug-2024

Signature :



Date : 12-Aug-2024