

Administrative**MEDICAL CLAIM FORM****Claim Ref:**

Patient Name : DEEPAK KUMAR . RAVEENDRA
Card No : I040-029-120358979-01
Policy Holder : DEEPAK KUMAR . RAVEENDRA
Payer Name : UNION INSURANCE COMPANY
TPA : E CARE - Blue Network
Validity : 02-01-2024 To 01-01-2025
Gender : Male
Date Of Birth : 08-Jan-1986
Patient's Tel No : 0547325221

Service Date : 17-Aug-2024**Network :** Green**Health Provider :** CITICARE MEDICAL CENTER LLC**Direct Access SP - YES**
Doctor's Name : AHSAN HUSSAIN
Co-Insurance :

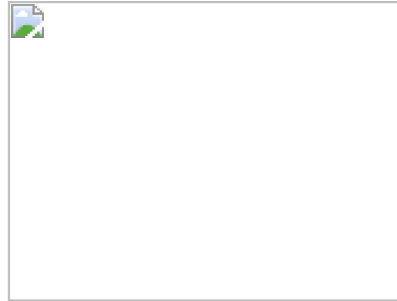
CONSULTATION	LAB/RADIOLOGY	PHYSIO	PHARMACY	IP	MATERNITY	DENTAL
10% max	NIL	NIL	NIL LIMIT	NIL	10%	NA

Remarks :

☐ Acute ☐ Pre-existing and chronic ☐ Maternity	
Chief Complaints : PC: FEVER PAIN IN ELBOW	Duration :
Vitals: Temp : 37.3 Bp :112 Pulse :60 Resp :18	
Clinical Findings:	
Diagnosis: G89.11 - Acute pain due to trauma,R50.9 - Fever, unspecified,	Date of Onset : 17/43/2024
Requested Investigations: 2190-106618-1001, PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION,0005-149902-1021, CLOFEN -(DICLOFENAC SODIUM : 75 MG/3ML) SOLUTION FOR INJECTION,96365, THER/PROPH/DIAG IV INF INIT,96372, THER/PROPH/DIAG INJ SC/IM,9.01, Follow Up Consultation GP	
Prescriptions: 0046-159501-0341 - (SERRATIOPEPTIDASE : 5 MG) ENTERIC COATED TABLETS,0139-116206-1171 - (CLAVULANIC ACID : 125 MG) (AMOXICILLIN : 875 MG) TABLETS,0005-107001-0051 - (CAFFEINE : 65 MG) (PARACETAMOL : 500 MG) CAPLETS,	
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 : 17-
Aug-
2024

Signature :

Date : 17-Aug-2024