Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	**: SEKH ESTYAK ALI SEKH AKTHAR ALI**
Card No	**: I040-029-118843245-01**
Policy Holder	**: SEKH ESTYAK ALI SEKH AKTHAR ALI**
Payer Name	**: UNION INSURANCE COMPANY**
TPA	**: E CARE - Blue Network**
Validity	**: 02-01-2024** To **01-01-2025**
Gender	**: Male**
Date Of Birth	**: 20-Dec-1992**
Patient's Tel No	**: 0528452339**

Service Date :18-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: ALLERGIC DERMATITIS **Duration** :

Vitals: Temp : 37.4 Bp :115 Pulse :102 Resp :18

Clinical Findings:

Diagnosis: L23.89 - Allergic contact dermatitis due to other agents,R10.13 - Epigastric pain, **Date of Onset** :18/49/2024

Requested Investigations: 0005-111805-1021, CHLOROHISTOL 10MG-(CHLORPHENIRAMINE MALEATE : 10 MG/ML) SOLUTION FOR INJECTION,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE-(DEXAMETHASONE : 4 MG/ML) SOLUTION FOR INJECTION,0005-174202-0781, RISEK 40MG,96365, THER/PROPH/DIAG IV INF INIT,96372, THER/PROPH/DIAG INJ SC/IM,86005, ALLERGEN SPECIFIC IGE QUAL MULTIALLERGEN SCREEN,9, Consultation GP **Estimated Cost** :

Prescriptions: 0006-149803-0651 - CLOBETASOL PROPIONATE,0195-123701-0391 - CETIRIZINE HCL, **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 :** 18-Aug-2024

Signature : **Date** : 18-Aug-2024