Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	: **DEEPAK KUMAR . RAVEENDRA**	**Service Date**	:**20-Aug-2024**
Card No	: **I040-029-120358979-01**	**Health Provider**	:**CITICARE MEDICAL CENTER LLC**
Policy Holder	: **DEEPAK KUMAR . RAVEENDRA**	**Doctor's Name**	:**AHSAN HUSSAIN**
Payer Name	: **UNION INSURANCE COMPANY**	**Co-Insurance**	:
TPA	: **E CARE - Blue Network**	**Remarks**	:
Validity	: **02-01-2024** To **01-01-2025**		
Gender	: **Male**		
Date Of Birth	: **08-Jan-1986**		
Patient's Tel No	: **0547325221**		

Network : Green

Direct Access SP - YES

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 : **Duration :**

Vitals: Temp : 36.1 Bp :120 Pulse :70 Resp :18

Clinical Findings:

Diagnosis: M25.521 - Pain in right elbow,G89.11 - Acute pain due to trauma, **Date of Onset** :20/26/2024

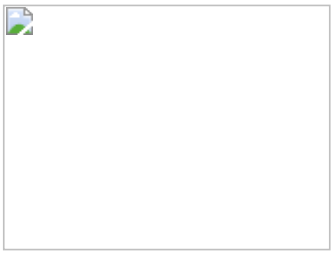
Requested Investigations: 9.01, Follow Up Consultation GP,0005-149902-1021, CLOFEN ,96372, THER/PROPH/DIAG INJ SC/IM **Estimated Cost :**

Prescriptions: 2093-596002-0432 - (DICLOFENAC DIETHYLAMINE : 23.2 MG / G) GEL, **Estimated Cost :**

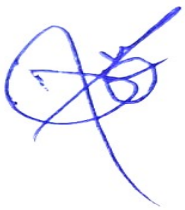
MEDICAL PRACTITIONER DECLARATION :

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 : AHSAN HUSSAIN **Stamp :**



Signature :



Date : 20-Aug-2024

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 : 20-Aug-2024