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 :**01-Sep-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 :110 Pulse :98 Resp :18

Clinical Findings:

Diagnosis: L23.89 - Allergic contact dermatitis due to other agents, **Date of Onset** :01/00/2024

Requested Investigations: 0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE,0005-111805-1021, CHLOROHISTOL 10MG,96372, THER/PROPH/DIAG INJ SC/IM,9, Consultation GP **Estimated Cost** :

Prescriptions: 0006-149803-0651 - CLOBETASOL PROPIONATE,0027-109206-0151 - (TERBINAFINE (AS HCL) : 1%) CREAM, **Estimated Cost** :

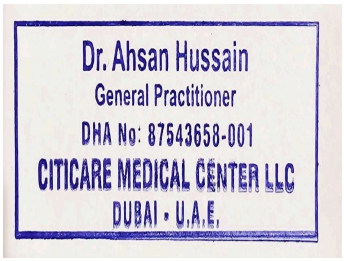
MEDICAL PRACTITIONER DECLARATION :

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.

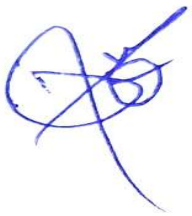
Dr's Name : AHSAN HUSSAIN **Stamp :**



Patient 's signature{Parent if minor} :

Date : 01-Sep-2024

Signature :



Date : 01-Sep-2024