## Administrative

# MEDICAL CLAIM FORM

## Claim Ref:

| | | | |
|---|---|---|---|
| **Patient Name** | : **CAROLYNE WANJIRU . KURIA** | **Service Date** | :**02-Sep-2024** **Network** : Green |
| **Card No** | : **I040-029-120035872-01** | **Health Provider** | :**CITICARE MEDICAL CENTER LLC** **Direct Access SP - YES** |
| **Policy Holder** | : **CAROLYNE WANJIRU . KURIA** | **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** | : **Female** | | |
| **Date Of Birth** | : **24-Apr-1993** | | |
| **Patient's Tel No** | : **0557172590** | | |

| 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 :** PC: HEAVY MENSTRUAL BLEEDING LAST 3 DAYS WITH CLOTS **Duration :**

**Vitals:**Temp : 36.8 Bp :102 Pulse :80 Resp :18

**Clinical Findings:**

**Diagnosis:** N91.5 - Oligomenorrhea, unspecified, **Date of Onset** : 02/29/2024

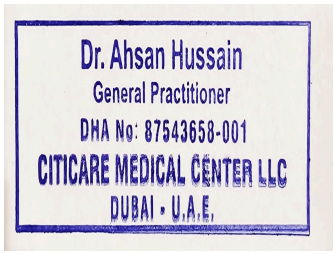
**Requested Investigations:** 9, Consultation GP **Estimated Cost** :

**Prescriptions:** **Estimated Cost** :

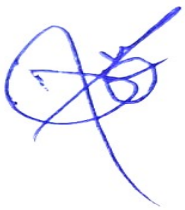
**MEDICAL PRACTITIONER DECLARATION :**

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** : 02-Sep-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 :** 02-Sep-2024