Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	: **JAHANGIR ALAM TAZUL ISLAM**	**Service Date**	:**04-Sep-2024**
Card No	: **I040-029-118710008-01**	**Health Provider**	:**CITICARE MEDICAL CENTER LLC**
Policy Holder	: **JAHANGIR ALAM TAZUL ISLAM**	**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	: **20-Apr-1978**		
Patient's Tel No	: **0568204143**		

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 : Pain and swelling on the dorsum of the left foot. Duration: 1month. No history of trauma. ALSO FREQUENCY OF URINATION. Not diabetic and not hypertensive. UA requested.

Duration:

Vitals: Temp : 35.7 Bp :118 Pulse :74 Resp :18

Clinical Findings:

Diagnosis: M25.572 - Pain in left ankle and joints of left foot,

Date of Onset : 04/11/2024

Requested Investigations: 9, Consultation GP

Estimated Cost :

Prescriptions:

Estimated Cost :

MEDICAL PRACTITIONER DECLARATION :

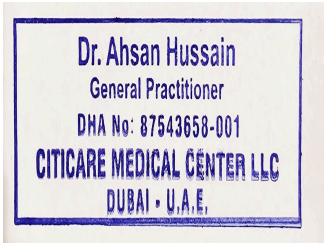
I declare that I am the patient's medical practitioner and that the particulars given are to the best of my knowledge true and correct.

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

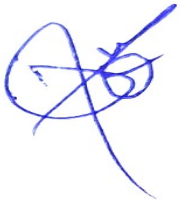
Stamp :



Patient 's signature{Parent if minor} :

Date : 04-Sep-2024

Signature :



Date : 04-Sep-2024