Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	**: JEET BAHADUR KHATRI**
Card No	**: I040-029-120209240-01**
Policy Holder	**: JEET BAHADUR KHATRI**
Payer Name	**: UNION INSURANCE COMPANY**
TPA	**: E CARE - Blue Network**
Validity	**: 02-01-2024** To **01-01-2025**
Gender	**: Male**
Date Of Birth	**: 02-Aug-1980**
Patient's Tel No	**: 0504753940**

Service Date **:07-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: COUGH **Duration** :

Vitals: Temp : 37.2 Bp :148 Pulse :88 Resp :18

Clinical Findings:

Diagnosis: R05 - Cough,L23.89 - Allergic contact dermatitis due to other agents, **Date of Onset** :07/41/2024

Estimated Cost :

Requested Investigations: 9, Consultation GP

Prescriptions: 0195-123701-0391 - CETIRIZINE HCL,0207-169703-1161 - (AMMONIUM CHLORIDE : N/A) (DIPHENHYDRAMINE : N/A) SYRUP,

Estimated Cost :

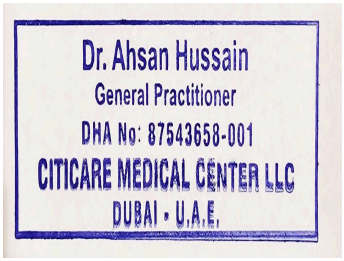
MEDICAL PRACTITIONER DECLARATION :

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.

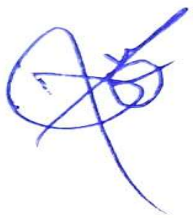
Dr's Name : AHSAN HUSSAIN **Stamp :**



Patient 's signature{Parent if minor} :

Date : 07-Sep-2024

Signature :



Date : 07-Sep-2024