Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	: **NISAL GURUNG**
Card No	: **I040-029-121353783-01**
Policy Holder	: **NISAL GURUNG**
Payer Name	: **UNION INSURANCE COMPANY**
TPA	: **E CARE - Blue Network**
Validity	: **11-09-2024** To **01-01-2025**
Gender	: **Male**
Date Of Birth	: **28-Feb-1989**
Patient's Tel No	: **0509869230**

Service Date :**30-Sep-2024** **Network** : Green

Health Provider :**CITICARE MEDICAL CENTER LLC** **Direct Access SP - YES**

Doctor's Name :**Humaira**

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 : co: ALLERGY AND REDNESS AROUND PENIS frequency of urine 15th sep. 2024 oe chest is clear no added sounds restless **Duration:**

Vitals: Temp : 36.5 Bp :144 Pulse :87 Resp :18

Clinical Findings:

Diagnosis: L23.9 - Allergic contact dermatitis, unspecified cause,N48.29 - Other inflammatory disorders of penis,R35.0 - Frequency of micturition,R73.9 - Hyperglycemia, unspecified, **Date of Onset** :30/42/2024

Requested Investigations: 9, Consultation GP,83036, Hemoglobin; glycosylated (A1C),82947, GLUCOSE QUANTITATIVE BLOOD XCPT REAGENT STRIP,83036, HEMOGLOBIN GLYCOSYLATED A1C **Estimated Cost** :

Prescriptions: 0159-140504-0151 - (CLOTRIMAZOLE : 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.

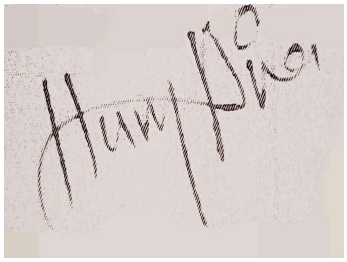
Dr's Name : Humaira

Stamp :

Patient 's signature{Parent if minor} :

Date : 30-Sep-2024

Signature :



Date : 30-Sep-2024