Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	**: Mansoor Ali Yameen Ali**
Card No	**: I040-029-113719090-01**
Policy Holder	**: Mansoor Ali Yameen Ali**
Payer Name	**: UNION INSURANCE COMPANY**
TPA	**: E CARE - Blue Network**
Validity	**: 02-01-2024** To **01-01-2025**
Gender	**: Male**
Date Of Birth	**: 25-Sep-1985**
Patient's Tel No	**: 0502245460**

Service Date **:15-Oct-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: REFILLL MEDICATION PAIN IN RIGHT HEEL **Duration :**

Vitals: Temp : 36.7 Bp :142 Pulse :91 Resp :18

Clinical Findings:

Diagnosis: I10 - Essential (primary) hypertension,R52 - Pain, unspecified,M79.18 - Myalgia, other site, **Date of Onset :**28/40/2024

Estimated Cost :

Requested Investigations: 9, Consultation GP

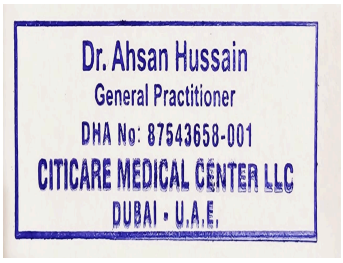
Prescriptions: 0278-107902-0391 - (IBUPROFEN : 400 MG) FILM COATED TABLETS,1217-373201-2401 - (TOLPERISONE : 150 MG) SUGAR COATED TABLETS,0252-155401-0391 - (LOSARTAN POTASSIUM : 50 MG) FILM COATED TABLETS, **Estimated Cost :**

MEDICAL PRACTITIONER DECLARATION :

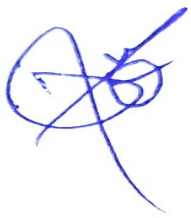
I declare that I am the patient's medical practitioner and that the particulars given are to the best of my knowledge true and correct.

Dr's Name : AHSAN HUSSAIN

Stamp :



Signature :



Date : 28-Oct-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 : 28-Oct-2024