

Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name : LAKAI MITRA
JATINDRA MITRA
MITRA
MITRA

Service Date : 19-Oct-2024

Network : Green

Health Provider : CITICARE MEDICAL
CENTER LLC

Direct Access SP - YES

Doctor's Name : AHSAN HUSSAIN

Card No : I040-029-
113719086-01

CONSULTATION	LAB/RADIOLOGY	PHYSIO	PHARMACY	IP	MATERNITY	DENTAL
10% max	NIL	NIL	NIL LIMIT	NIL	10%	NA

Co-Insurance :

Policy Holder : LAKAI MITRA
JATINDRA MITRA
MITRA

Remarks :

Payer Name : UNION
INSURANCE
COMPANY

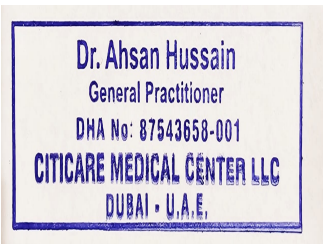
TPA : E CARE - Blue
Network

Validity : 02-01-2024 To
01-01-2025

Gender : Male

Date Of Birth : 05-Mar-1982

Patient's Tel No : 508842935

☐ Acute	☐ Pre-existing and chronic	☐ Maternity
Chief Complaints : pc: itching in head fungal infection		
Duration :		
Vitals: Temp : 36.4 Bp :120 Pulse :76 Resp :18		
Clinical Findings:		
Diagnosis: L23.89 - Allergic contact dermatitis due to other agents,R21 - Rash and other nonspecific skin eruption, Date of Onset: 19/35/2024		
Estimated Cost :		
Requested Investigations: 9, Consultation GP		
Estimated Cost :		
Prescriptions: 0006-149803-0651 - (CLOBETASOL PROPIONATE : 0.5 MG/G) OINTMENT,		
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} 
Signature : 	Date : 19-Oct-2024	Date : Oct-2024