

Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name : ANITA MAGAR DHANJIT
MAGAR
Card No : I040-029-119014964-01
Policy Holder : ANITA MAGAR DHANJIT
MAGAR

Payer Name : UNION INSURANCE
COMPANY

TPA : E CARE - Green Network

Validity : 01-10-2024 To 30-09-
2025

Gender : Female

Date Of Birth : 20-Oct-1996

Patient's Tel No : 0544398628

Service Date :29-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: BURNING URINE PAIN IN URINE FEVER

Duration :

Vitals:Temp : 36.7 Bp :100 Pulse :72 Resp :18

Clinical Findings:

Diagnosis: N39.0 - Urinary tract infection, site not specified,R52 - Pain, unspecified,

Date of Onset :29/10/2024

Requested Investigations: 0005-107704-0802, TRIAXONE I.V.-(CEFTRIAXONE : 1 G) POWDER FOR INJECTION,96365, THER/PROPH/DIAG IV INF INIT,2190-106618-1001, PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION,86140, C REACTIVE PROTEIN,9, Consultation GP,81001, URNLS DIP STICK/TABLET REAGENT AUTO MICROSCOPY

Estimated :
Cost

Prescriptions: 5278-440704-0452 - (FOSFOMYCIN (AS TROMETAMOL) : 3 G) GRANULES,0054-103201-0391 - (CIPROFLOXACIN : 500 MG) FILM COATED TABLETS,

Estimated :
Cost

MEDICAL PRACTITIONER DECLARATION :

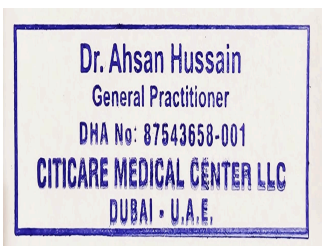
I declare that I am the patient's medical practitioner and that the particulars given are to the best of my knowledge true and correct.

PATIENT'S DECLARATION :

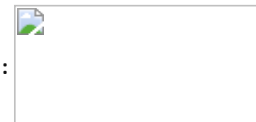
I hereby authorize any Healthcare provider, Insurer, Employer or other organization to release any information regarding my medical condition & history for purpose of determining insurance benefits.

Dr's Name : AHSAN HUSSAIN

Stamp :



Patient 's
signature{Parent :
if minor}



29-
Date : Oct-
2024

Signature :

Date : 29-Oct-2024