

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 :08-Nov-2024

Health Provider :CITICARE MEDICAL CENTER LLC

Doctor's Name :AHSAN HUSSAIN

Co-Insurance :

Remarks :

Network : Green

Direct Access SP - YES

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

☐ Acute

☐ Pre-existing and chronic

☐ Maternity

Chief Complaints : pc: fever 1 day flu epigastric pain nauseaDuration :

Vitals:

Clinical Findings:

Diagnosis: J06.9 - Acute upper respiratory infection, unspecified,J00 - Acute nasopharyngitis [common cold],K29.00 - Date of :08/56/2024
Acute gastritis without bleeding,R11.2 - Nausea with vomiting, unspecified,Onset

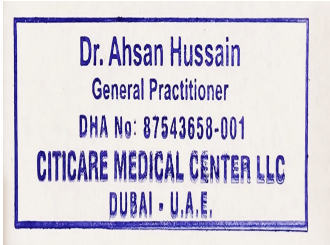
Estimated Cost :
Requested Investigations: 9, Consultation GP

Estimated Cost :
Prescriptions:

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

Signature :

Stamp :

Date : 08-Nov-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 : Nov-2024