Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	**: RAMESH CHANDRA PATIDAR**
Card No	**: I040-029-113722477-01**
Policy Holder	**: RAMESH CHANDRA PATIDAR**
Payer Name	**: UNION INSURANCE COMPANY**
TPA	**: E CARE - Blue Network**
Validity	**: 02-01-2024** To **01-01-2025**
Gender	**: Male**
Date Of Birth	**: 15-Jul-1978**
Patient's Tel No	**: 0563834759**

Service Date **:09-Nov-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 in stoamch 2 days insomnia 1 day **Duration :**

Vitals: Temp : 36.8 Bp :150 Pulse :72 Resp :18

Clinical Findings:

Diagnosis: K21.9 - Gastro-esophageal reflux disease without esophagitis,K29.00 - Acute gastritis without bleeding,R10.13 - Epigastric pain,R14.0 - Abdominal distension (gaseous), **Date of Onset** :09/14/2024

Requested Investigations: 0005-174202-0781, RISEK 40MG,0188-135906-2441, PULMICORT,0005-150403-1021, PREMOSAN ,96360, HYDRATION IV INFUSION INIT,0102-111908-1001, SODIUM CHLORIDE B.P.,96365, THER/PROPH/DIAG IV INF INIT,96372, THER/PROPH/DIAG INJ SC/IM,9, Consultation GP,94640, AIRWAY INHALATION TREATMENT **Estimated Cost** :

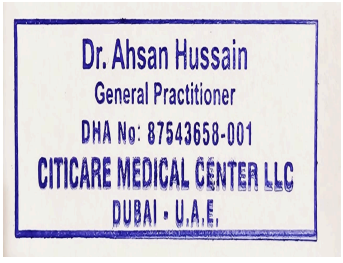
Prescriptions: 0005-136501-0392 - (HYOSCINE : 10 MG FILM COATED TABLETS,0207-533801-1451 - (ESOMEPRAZOLE (AS MAGNESIUM : 20 MG CAPSULES (HARD GELATIN,6986-151717-0061 - (SIMETHICONE : 250 MG) CAPSULES, **Estimated Cost** :

MEDICAL PRACTITIONER DECLARATION :

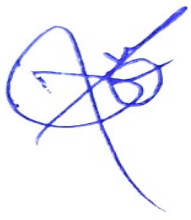
I declare that I am the patient's medical practitioner and that the particulars given are to the best of my knowledge true and correct.

Dr's Name : AHSAN HUSSAIN

Stamp :



Signature :



Date : 09-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 : 09-Nov-2024