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 :**11-Dec-2024**
Health Provider :**CITICARE MEDICAL CENTER LLC**
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 :

Network : Green
Direct Access SP - YES

☐ **Acute** ☐ **Pre-existing and chronic** ☐ **Maternity**

Chief Complaints : pc: fever 2 days 09/12/2024 pain in right feet came to refill medication for hypertension **Duration:**

Vitals: Temp : 37.5 Bp :130 Pulse :100 Resp :18

Clinical Findings:

Diagnosis: L03.032 - Cellulitis of left toe,J00 - Acute nasopharyngitis [common cold],R05 - Cough,R07.0 - Pain in throat,R50.9 - Fever, unspecified,R51.9 - Headache, unspecified,I10 - Essential (primary) hypertension,E79.0 - Hyperuricemia w/o signs of inflam arthrit and tophaceous dis, **Date of Onset** :12/16/2024

Estimated Cost :

Requested Investigations: 84550, URIC ACID BLOOD,9, Consultation GP

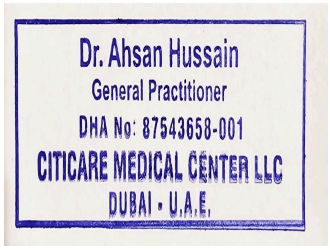
Prescriptions: 0195-123701-0391 - (CETIRIZINE HCL : 10 MG) FILM COATED TABLETS,0195-148602-0391 - (CLARITHROMYCIN : 500 MG) FILM COATED TABLETS,0252-185801-0391 - (DIPHENHYDRAMINE : 25 MG) (PARACETAMOL : 500 MG) (PSEUDOEPHEDRINE : 30 MG) FILM COATED TABLETS,0252-155401-0391 - (LOSARTAN POTASSIUM : 50 MG) FILM COATED TABLETS,0278-107902-0391 - (IBUPROFEN : 400 MG) FILM COATED TABLETS, **Estimated Cost** :

MEDICAL PRACTITIONER DECLARATION :

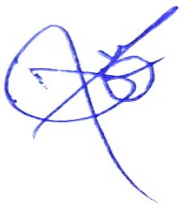
I declare that I am the patient's medical practitioner and that the particulars given are to the best of my knowledge true and correct.

Dr's Name : AHSAN HUSSAIN

Stamp :



Signature :



Date : 12-Dec-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 : 12-Dec-2024