Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	**: FETHI ACHI**
Card No	**: I040-029-121180791-01**
Policy Holder	**: FETHI ACHI**
Payer Name	**: UNION INSURANCE COMPANY**
TPA	**: E CARE - Blue Network**
Validity	**: 08-08-2024** To **01-01-2025**
Gender	**: Male**
Date Of Birth	**: 17-Nov-1999**
Patient's Tel No	**: 0581127489**

Service Date :11-Dec-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 : **Duration** :

Vitals: Temp : 36.8 Bp :130 Pulse :80 Resp :18

Clinical Findings:

Diagnosis: G43.909 - Migraine, unsp, not intractable, without status migrainosus, **Date of Onset** :11/20/2024

Requested Investigations: 9, Consultation GP **Estimated Cost** :

Prescriptions: **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 :

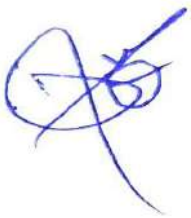
I hereby authorize any Healthcare provider, Insurer, Employer or other organization to release any information regarding my medical condition & history for purpose of determining insurance benefits.

Dr's Name : AHSAN HUSSAIN **Stamp :**

Patient 's signature{Parent if minor} :

Date : 11-Dec-2024

Signature :



Date : 11-Dec-2024