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**
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 : **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** : 12/29/2024

Estimated Cost :

Requested Investigations: 9, Consultation GP

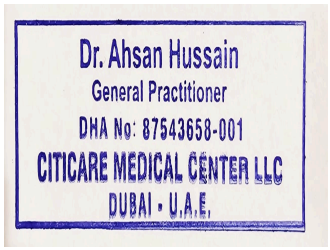
Estimated Cost :

Prescriptions:

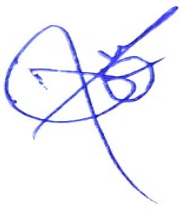
MEDICAL PRACTITIONER DECLARATION :

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 **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