

Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name : THI HA AUNG
Card No : I040-029-120585630-01
Policy Holder : THI HA AUNG
Payer Name : UNION INSURANCE COMPANY
TPA : E CARE - Blue Network
Validity : 02-01-2024 To 01-01-2025
Gender : Male
Date Of Birth : 16-Feb-2001
Patient's Tel No : 0559542312

Service Date :14-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 : pc: low back pain

Duration :

Vitals:Temp : 38.9 Bp :131 Pulse :117 Resp :18

Clinical Findings:

Diagnosis: M54.5 - Low back pain,M62.830 - Muscle spasm of back,

Date of Onset :14/35/2024

Requested Investigations: 0005-149902-1021, CLOFEN ,96372, THER/PROPH/DIAG INJ SC/IM,9, Consultation GP

Estimated Cost :

Prescriptions: 1217-373201-2401 - (TOLPERISONE : 150 MG) SUGAR COATED TABLETS,2093-596002-0431 - (DICLOFENAC DIETHYLAMINE : 23.2 MG / G) GEL,0278-107902-0391 - (IBUPROFEN : 400 MG) FILM COATED TABLETS,

Estimated Cost :

MEDICAL PRACTITIONER DECLARATION :

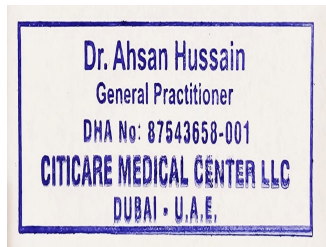
I declare that I am the patient's medical practitioner and that the particulars given are to the best of my knowledge true and correct.

PATIENT'S DECLARATION :

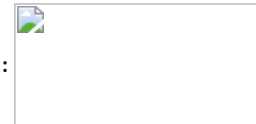
I hereby authorize any Healthcare provider, Insurer, Employer or other organization to release any information regarding my medical condition & history for purpose of determining insurance benefits.

Dr's Name : AHSAN HUSSAIN

Stamp :



Patient's signature{Parent : if minor}



Date : Dec-2024

Signature :

Date : 14-Dec-2024