Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name : Ramesh Kumar
Card No : I011-029-120467737-02
Policy Holder : Ramesh Kumar
Payer Name : AL SAGR NATIONAL INSURANCE COMPANY
TPA : E CARE - Blue Network
Validity : 19-06-2024 To 18-06-2025
Gender : Male
Date Of Birth : 05-Jan-1997
Patient's Tel No : 0545766439

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: fever celulitis in big toe right side since yesterday no history of trauma or injury **Duration:**

Vitals: Temp : 37.5 Bp :130 Pulse :76 Resp :18

Clinical Findings:

Diagnosis: R50.9 - Fever, unspecified,L03.031 - Cellulitis of right toe,M79.676 - Pain in unspecified toe(s), **Date of Onset** :14/36/2024

Estimated Cost :

Requested Investigations: 9, Consultation GP

Prescriptions: 0278-107902-0391 - (IBUPROFEN : 400 MG) FILM COATED TABLETS,0139-116206-1171 - (CLAVULANIC ACID : 125 MG) (AMOXICILLIN : 875 MG) TABLETS,

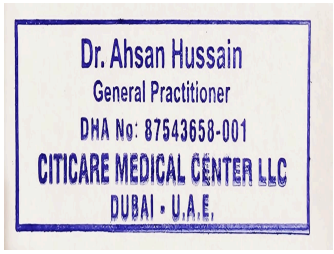
Estimated Cost :

MEDICAL PRACTITIONER DECLARATION :

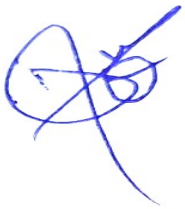
I declare that I am the patient's medical practitioner and that the particulars given are to the best of my knowledge true and correct.

Dr's Name : AHSAN HUSSAIN

Stamp :



Signature :



Date : 14-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 : 14-Dec-2024