Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	: **MOHAMMED SHAHAB UDDIN ABDUL MABUD**	**Service Date**	**:14-Dec-2024**
Card No	: **I040-029-119600415-01**	**Health Provider**	**:CITICARE MEDICAL CENTER LLC**
Policy Holder	: **MOHAMMED SHAHAB UDDIN ABDUL MABUD**	**Doctor's Name**	**:AHSAN HUSSAIN**
Payer Name	: **UNION INSURANCE COMPANY**	**Co-Insurance**	:
TPA	: **E CARE - Blue Network**	**Remarks**	:
Validity	: **02-01-2024** To **01-01-2025**		
Gender	: **Male**		
Date Of Birth	: **08-Mar-1985**		
Patient's Tel No	: **0581676397**		

Network : Green

Direct Access SP - YES

CONSULTATION	LAB/RADIOLOGY	PHYSIO	PHARMACY	IP	MATERNITY	DENTAL
10% max	NIL	NIL	NIL LIMIT	NIL	10%	NA

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

Chief Complaints : pc: vomiting 3 episodes since afternoon 14/12/2024 nausea fever epigastric pain dehydration **Duration:**

Vitals: Temp : 37.5 Bp :118 Pulse :61 Resp :18

Clinical Findings:

Diagnosis: K29.00 - Acute gastritis without bleeding,R11.2 - Nausea with vomiting, unspecified,R50.9 - Fever, unspecified,K21.9 - Gastro-esophageal reflux disease without esophagitis,R10.13 - Epigastric pain, **Date of Onset** :14/33/2024

Requested Investigations: 0005-150403-1021, PREMOSAN -(METOCLOPRAMIDE : 10 MG/2ML) SOLUTION FOR INJECTION,0102-152902-1001, LACTATED RINGERS INJECTION USP,0005-136504-1021, SCOPINAL,0005-174202-0781, RISEK 40MG,96365, THER/PROPH/DIAG IV INF INIT,96372, THER/PROPH/DIAG INJ SC/IM,96360, HYDRATION IV INFUSION INIT,96374, THER/PROPH/DIAG INJ IV PUSH,9, Consultation GP **Estimated Cost** :

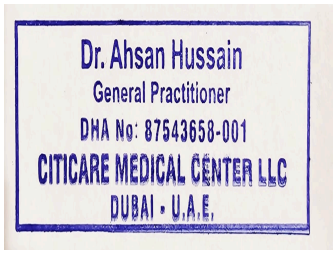
Prescriptions: 0006-106601-0393 - (PARACETAMOL : 500 MG) FILM COATED TABLETS,0207-533801-1451 - (ESOMEPRAZOLE (AS MAGNESIUM : 20 MG CAPSULES (HARD GELATIN,0005-136501-0392 - (HYOSCINE : 10 MG) FILM COATED TABLETS,0005-150407-1172 - (METOCLOPRAMIDE : 10 MG TABLETS, **Estimated Cost** :

MEDICAL PRACTITIONER DECLARATION :

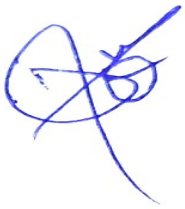
I declare that I am the patient's medical practitioner and that the particulars given are to the best of my knowledge true and correct.

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