

## Administrative

## MEDICAL CLAIM FORM

## Claim Ref:

Patient Name : JEET BAHADUR KHATRI  
Card No : I040-029-120209240-01  
Policy Holder : JEET BAHADUR KHATRI  
Payer Name : UNION INSURANCE COMPANY  
TPA : E CARE - Blue Network  
Validity : 02-01-2024 To 01-01-2025  
Gender : Male  
Date Of Birth : 02-Aug-1980  
Patient's Tel No : 0504753940

Service Date :17-Dec-2024

Network : Green

Health Provider :CITICARE MEDICAL CENTER LLC  
Doctor's Name :Enomen Goodluck

Direct Access SP - YES

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: Headache, fever, weakness, inability to sleep and generalized body pain. Duration:

Duration: 2days. Has cough and noisy breathing.

Vitals:Temp : 36.4 Bp :136 Pulse :86 Resp :18

## Clinical Findings:

Diagnosis: J20.9 - Acute bronchitis, unspecified,R50.9 - Fever, unspecified,R05 - Cough,K29.00 - Acute gastritis without bleeding,N39.0 - Urinary tract infection, site not specified,

Date of Onset :17/54/2024

Requested Investigations: 0005-174202-0781, RISEK 40MG,0005-149902-1021, CLOFEN ,96372, THER/PROPH/DIAG INJ SC/IM,96374, THER/PROPH/DIAG INJ IV PUSH,9.01, Follow Up Consultation GP

Estimated :  
Cost

Prescriptions: 0005-116702-2481 - (DIPHENHYDRAMINE : 12.5 MG/5ML) SYRUP (SUGAR FREE),0054-103201-0391 - (CIPROFLOXACIN : 500 MG) FILM COATED TABLETS,0137-242802-0341 - (PANTOPRAZOLE (AS SODIUM) : 40 MG) ENTERIC COATED TABLETS,0252-389902-1171 - (LORATADINE : 5 MG (PSEUDOEPHEDRINE SULPHATE : 120 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.

## PATIENT'S DECLARATION :

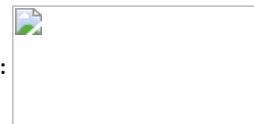
I hereby authorize any Healthcare provider, Insurer, Employer or other organization to release any information regarding my medical condition &amp; history for purpose of determining insurance benefits.

Dr's Name : Enomen Goodluck

Stamp :



Patient 's signature{Parent : if minor}



Date : Dec-2024

Signature :

Date : 17-Dec-2024