

Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name : NINO MANALO . ORTEGA
Card No : I040-029-119827244-01
Policy Holder : NINO MANALO . ORTEGA
Payer Name : UNION INSURANCE COMPANY
TPA : E CARE - Blue Network
Validity : 02-01-2025 To 01-01-2026
Gender : Male
Date Of Birth : 07-Aug-1997
Patient's Tel No : 052671369

Service Date :11-Jan-2025 Network : Green
Health Provider :CITICARE MEDICAL CENTER LLC Direct Access SP - YES
Doctor's Name :SANDIA

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 : cough which is dry , trouble breathing, myalgia fever for 3 days no other Duration:
med conditions 0/e : pharynx hyperemia chest congested

Vitals:Temp : 37.4 Bp :130 Pulse :58 Resp :18

Clinical Findings:

Diagnosis: J06.9 - Acute upper respiratory infection, unspecified,R05 - Cough,R50.9 - Fever, unspecified, Date of Onset :11/17/2025

Requested Investigations: 85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC
COUNT,86140, C REACTIVE PROTEIN,2190-106618-1001, PARAFUSIV I.V. 10MG/ML-(PARACETAMOL :
10 MG/ML) SOLUTION FOR INFUSION,0195-107704-0801, CEFTRIAXONE-TABUK IV,0005-149902-
1021, CLOFEN -(DICLOFENAC SODIUM : 75 MG/3ML) SOLUTION FOR INJECTION,96374,
THER/PROPH/DIAG INJ IV PUSH,96365, THER/PROPH/DIAG IV INF INIT,96372, THER/PROPH/DIAG INJ
SC/IM,9, Consultation GP

Estimated :
Cost

Prescriptions: 0837-277601-1161 - (OXOMEMAZINE : 0.33 MG/ML) SYRUP,0005-107001-0051 -
(CAFFEINE : 65 MG (PARACETAMOL : 500 MG CAPLETS,0397-116207-0391 - (AMOXICILLIN : 500 MG
(CLAVULANIC ACID : 125 MG FILM COATED TABLETS,0195-123701-0391 - (CETIRIZINE HCL : 10 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.

Dr's Name : SANDIA

Stamp :



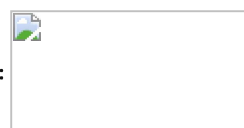
Signature :

Date : 11-Jan-2025

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}



11-
Date : Jan-
2025