

Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name : Sachin Pandurang
Vinhkerkar
Card No : I040-029-113718954-01

Policy Holder : Sachin Pandurang
Vinhkerkar

Payer Name : UNION INSURANCE
COMPANY

TPA : E CARE - Blue Network

Validity : 02-01-2025 To 01-01-2026

Gender : Male

Date Of Birth : 07-Jan-1984

Patient's Tel No : 0503667303

Service Date :12-Jan-2025

Network

: Green

Health :CITICARE MEDICAL CENTER LLC

Direct Access SP - YES

Provider
Doctor's Name :Humaira

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 : Duration :

Vitals:

Clinical Findings:

Diagnosis: J06.9 - Acute upper respiratory infection, unspecified,J30.9 - Allergic rhinitis, unspecified,R05 - Cough,R50.9 - Fever, unspecified,K29.00 - Acute gastritis without bleeding,R06.2 - Wheezing, Date of Onset :12/13/2025

Requested Investigations: 9.01, Follow Up Consultation GP,96365, THER/PROPH/DIAG IV INF INIT,0195-107704-0801, CEFTRIAXONE-TABUK 1 GM IV

Estimated Cost :

Estimated Cost :

Prescriptions:

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 :

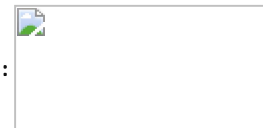
I hereby authorize any Healthcare provider, Insurer, Employer or other organization to release any information regarding my medical condition & history for purpose of determining insurance benefits.

Dr's Name : Humaira

Stamp :



Patient's signature{Parent : if minor}



Date : Jan-2025

Signature :

Date : 12-Jan-2025