Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	**: IDRISSA JUMANNE LIKYPILA**
Card No	**: I040-029-121370818-01**
Policy Holder	**: IDRISSA JUMANNE LIKYPILA**
Payer Name	**: UNION INSURANCE COMPANY**
TPA	**: E CARE - Blue Network**
Validity	**: 02-01-2025** To **01-01-2026**
Gender	**: Male**
Date Of Birth	**: 20-Oct-1987**
Patient's Tel No	**: 0544525804**

Service Date **:13-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 : feeling fatigued , fever , no other med conditions **Duration :**

Vitals: Temp : 36.5 Bp :120 Pulse :70 Resp :18

Clinical Findings:

Diagnosis: J39.9 - Disease of upper respiratory tract, unspecified, **Date of Onset** : 13/59/2025

Requested Investigations: 85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,80047, BASIC METABOLIC PANEL CALCIUM IONIZED,9, Consultation GP **Estimated Cost** :

Prescriptions: 2150-575201-1171 - (CALCIUM : 400 MG (VITAMIN D3 : 200 IU (MAGNESIUM : 100 MG (ZINC : 4 MG TABLETS,1217-373201-2401 - (TOLPERISONE : 150 MG) SUGAR COATED TABLETS,0005-107001-0051 - (CAFFEINE : 65 MG) (PARACETAMOL : 500 MG) CAPLETS, **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 :

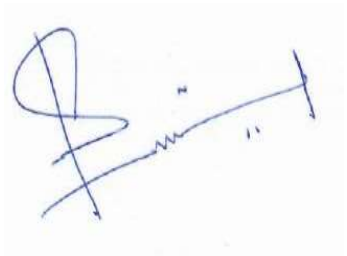
I hereby authorize any Healthcare provider, Insurer, Employer or other organization to release any information regarding my medical condition & history for purpose of determining insurance benefits.

Dr's Name : SANDIA **Stamp :**

Patient 's signature{Parent if minor} :

Date : 13-Jan-2025

Signature :



Date : 13-Jan-2025