

Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name : VALLARI VIJAY
POHARKAR
Card No : I022-029-121894114-01
Policy Holder : VALLARI VIJAY
POHARKAR
Payer Name : TAKAFUL EMARAT
TPA : E CARE - Blue Network
Validity : 25-12-2024 To 24-12-2025
Gender : Female
Date Of Birth : 03-Jan-1996
Patient's Tel No : +919112222334

Service Date :15-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 : follow up to discuss renal scans left renal calculi 3 mm , 2mm left ureter **Duration:** 6 mm cuasing hydronephrosis uric acid normal adv : parathyroid hormone tst

Vitals:Temp : 36 Bp :112 Pulse :81 Resp :18

Clinical Findings:

Diagnosis: N10 - Acute pyelonephritis,R10.30 - Lower abdominal pain, unspecified, **Date of Onset** :15/08/2025

Estimated Cost :

Requested Investigations: 9.01, Follow Up Consultation GP

Prescriptions: 0248-187801-1171 - (DILOXANIDE FUROATE : 250 MG) (METRONIDAZOLE : 200 MG) **Estimated :**

TABLETS,1161-167506-1171 - (FUROSEMIDE : 20 MG TABLETS,0097-136501-0392 - (HYOSCINE : 10 MG**Cost**

FILM COATED TABLETS,1947-548101-0081 - (CRANBERRY EXTRACT : 120 MG) CHEWABLE

TABLETS,1393-238401-1451 - (TAMSULOSIN HCL : 0.4 MG) CAPSULES (HARD GELATIN),

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 :

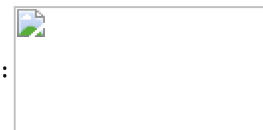
I hereby authorize any Healthcare provider, Insurer, Employer or other organization to release any information regarding my medical condition & history for purpose of determining insurance benefits.

Dr's Name : SANDIA

Stamp :



Patient's signature{Parent : if minor}



15-
Date : Jan-
2025

Signature :

Date : 15-Jan-2025