

Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name : FETHI ACHI
Card No : I040-029-121180791-01
Policy Holder : FETHI ACHI
Payer Name : UNION INSURANCE COMPANY
TPA : E CARE - Blue Network
Validity : 02-01-2025 To 01-01-2026
Gender : Male
Date Of Birth : 17-Nov-1999
Patient's Tel No : 0581127489

Service Date : 20-Jan-2025
Health Provider : CITICARE MEDICAL CENTER LLC
Doctor's Name : Humaira
Co-Insurance :

CONSULTATION	LAB/RADIOLOGY	PHYSIO	PHARMACY	IP	MATERNITY	DENTAL
10% max	NIL	NIL	NIL LIMIT	NIL	10%	NA

Network : Green
Direct Access SP - YES
Remarks :

☐ Acute
 ☐ Pre-existing and chronic
 ☐ Maternity

Chief Complaints : co fever on and off taking penadol at home dry cough running nose bodyache 15th jan. 2025 oe enlarge tonsills chest is congested no added sounds restless smoker

Duration:

Vitals: Temp : 36.8 Bp :126 Pulse :73 Resp :18

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,

Date of Onset : 20/24/2025

Requested Investigations: 85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,86140, C REACTIVE PROTEIN,0188-135906-2441, PULMICORT-(BUDESONIDE : 0.5 MG/ML) SUSPENSION FOR NEBULIZATION,94640, AIRWAY INHALATION TREATMENT,9, Consultation GP

Estimated : Cost

Prescriptions: 0005-116702-2481 - (DIPHENHYDRAMINE : 12.5 MG/5ML SYRUP (SUGAR FREE,0207-533801-1451 - (ESOMEPRAZOLE (AS MAGNESIUM : 20 MG CAPSULES (HARD GELATIN,0097-127405-0391 - (AZITHROMYCIN : 500 MG FILM COATED TABLETS,0005-107001-0051 - (CAFFEINE : 65 MG (PARACETAMOL : 500 MG CAPLETS,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.

PATIENT'S DECLARATION :

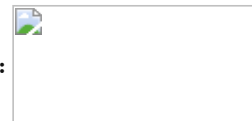
I hereby authorize any Healthcare provider, Insurer, Employer or other organization to release any information regarding my medical condition & history for purpose of determining insurance benefits.

Dr's Name : Humaira

Stamp :



Patient 's signature{Parent : if minor}



Date : 20-Jan-2025

Signature :

Date : 20-Jan-2025