

Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name : MARVIN MOLINA JOSE

Card No : I040-029-113718524-01

Policy Holder : MARVIN MOLINA JOSE

Payer Name : UNION INSURANCE COMPANY

TPA : E CARE - Blue Network

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

Gender : Male

Date Of Birth : 13-Nov-1978

Patient's Tel No : 0524018876

Service Date :24-Jan-2025

Health Provider :CITICARE MEDICAL CENTER LLC

Doctor's Name :Humaira

Network : Green

Direct Access SP - YES

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 : co skin eruption from 1 month dec.2024 oe allergic rash on both legs chest is clear no added sounds restless

Vitals:Temp : 37.3 Bp :170 Pulse :92 Resp :18

Clinical Findings:

Diagnosis: R21 - Rash and other nonspecific skin eruption,T78.40XS - Allergy, unspecified, sequela,C84.00 - Mycosis fungoides, unspecified site, **Date of Onset** :24/00/2025

Requested Investigations: 0005-111805-1021, CHLOROISTOL 10MG,96372, THER/PROPH/DIAG INJ SC/IM,86005, ALLERGEN SPECIFIC IGE QUAL MULTIALLERGEN SCREEN,9, Consultation GP **Estimated Cost** :

Prescriptions: 0027-109206-0151 - (TERBINAFINE (AS HCL : 1% CREAM,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 :

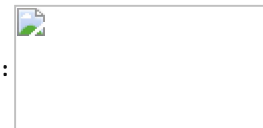
I hereby authorize any Healthcare provider, Insurer, Employer or other organization to release any information regarding my medical condition & history for purpose of determining insurance benefits.

Dr's Name : Humaira

Stamp :



Patient's signature{Parent : if minor}



Date : Jan-2025

Signature :

Date : 24-Jan-2025