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 **:27-Jan-2025** **Network** **:** Green

Health Provider **:CITICARE MEDICAL CENTER LLC** **Direct Access SP - YES**

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 : left renal calculi 3 mm , 2mm left ureter 6 mm cuasing hydronephrosis now complain of pain inthe lumber region oe pain is severe chest is clear no added sounds restless **Duration:**

Vitals: Temp : 36 Bp :130 Pulse :81 Resp :18

Clinical Findings:

Diagnosis: N39.0 - Urinary tract infection, site not specified,N20.2 - Calculus of kidney with calculus of ureter,R52 - Pain, unspecified,N10 - Acute pyelonephritis, **Date of Onset** **:**27/30/2025

Requested Investigations: 85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,86140, C REACTIVE PROTEIN,0102-111908-1001, SODIUM CHLORIDE B.P.,0005-149902-1021, CLOFEN -(DICLOFENAC SODIUM : 75 MG/3ML) SOLUTION FOR INJECTION,96360, HYDRATION IV INFUSION INIT,96372, THER/PROPH/DIAG INJ SC/IM,30042033, CIPROFLOXACIN,0002-116601-1001, METRONIDAZOLE : 500 MG/100ML) SOLUTION FOR INFUSION ,9, Consultation GP,96365, IV INFUSION THERAPY -Antibiotics & Others **Estimated Cost** **:**

Prescriptions: 0195-116604-0391 - (METRONIDAZOLE : 500 MG FILM COATED TABLETS,3114-482003-0391 - (CIPROFLOXACIN (AS HYDROCHLORIDE) : 500 MG) FILM COATED TABLETS,0027-142201-0831 - (DICLOFENAC POTASSIUM : 50 MG) POWDER FOR SOLUTION,0097-658501-0252 - (TARTARIC ACID : 0.89G) (SODIUM BICARBONATE : 1.76G) (CRANBERRY EXTRACT : 0.25 G) (TRI SODIUM CITRATE ANHYDROUS : 0.63G) (CITRIC ACID ANHYDROUS : 0.72G) EFFERVESCENT GRANULES, **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.

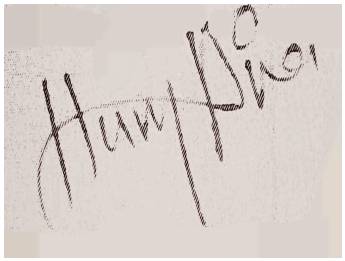
Dr's Name : Humaira

Stamp :

Patient 's signature{Parent if minor} :

Date : 27-Jan-2025

Signature :



Date : 27-Jan-2025