

Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name

: JEEVAN GAIRE

Card No

: I040-029-120758200-01

Policy Holder

: JEEVAN GAIRE

Payer Name

: UNION INSURANCE COMPANY

TPA

: E CARE - Blue Network

Validity

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

Gender

: Male

Date Of Birth

: 10-Oct-1996

Patient's Tel No

: 0521627307

Service Date

:04-Feb-2025

Health Provider

:CITICARE MEDICAL CENTER LLC

Doctor's Name

:Humaira

Co-Insurance

:

Remarks

:

Network

: Green

Direct Access SP - YES

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

☐ Acute

☐ Pre-existing and chronic

☐ Maternity

Chief Complaints

: co fever on and off productive cough nasal congestion 1st feb. 2025 oe chest is congested no added sounds restless somker

Vitals

:Temp : 36 Bp :125 Pulse :86 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

:04/25/2025

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,0669-533802-0391 - (ESOMEPRAZOLE (AS MAGNESIUM) : 40 MG) FILM COATED TABLETS,0005-107001-0051 - (CAFFEINE : 65 MG (PARACETAMOL : 500 MG CAPLETS,0097-127405-0391 - (AZITHROMYCIN : 500 MG FILM COATED TABLETS,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

:

Signature

:

Date

: 04-Feb-2025

Patient 's signature{Parent : if minor}

:

Date

: Feb-2025