Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	**: NABIN KUMAR DAS**
Card No	**: I040-029-119613171-01**
Policy Holder	**: NABIN KUMAR DAS**
Payer Name	**: UNION INSURANCE COMPANY**
TPA	**: E CARE - Blue Network**
Validity	**: 02-01-2025** To **01-01-2026**
Gender	**: Male**
Date Of Birth	**: 03-May-1999**
Patient's Tel No	**: 0542219507**

Service Date :**04-Jul-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 : FEVER WITH CHILLS SINCE LAST NIGHT HEADACHE RUNNY NOSE PRODUCTIVE COUGH BODY PAIN ON EXAM CHEST IN CLEAR THROAT LOOKS INFLAMMED **Duration:**

Vitals: Temp : 37.9 Bp :136 Pulse :108 Resp :18

Clinical Findings:

Diagnosis: R50.9 - Fever, unspecified,J06.9 - Acute upper respiratory infection, unspecified,J30.9 - Allergic rhinitis, unspecified,R51.9 - Headache, unspecified,R53.1 - Weakness, **Date of Onset** :04/27/2025

Requested Investigations: 9, Consultation GP,85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,86140, C REACTIVE PROTEIN,96365, THER/PROPH/DIAG IV INF INIT,2190-106618-1001, PARAFUSIV **Estimated Cost** :

Prescriptions: 0139-116207-1171 - (CLAVULANIC ACID : 125 MG) (AMOXICILLIN : 500 MG) TABLETS,0027-265802-1161 - (BUTAMIRATE DIHYDROGEN CITRATE : 0.15% W/V) SYRUP,0006-106601-0392 - (PARACETAMOL : 500 MG) FILM COATED TABLETS,0195-123701-0391 - (CETIRIZINE HCL : 10 MG) FILM COATED TABLETS, **Estimated Cost** :

MEDICAL PRACTITIONER DECLARATION :

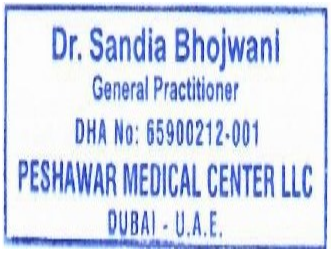
I declare that I am the patient's medical practitioner and that the particulars given are to the best of my knowledge true and correct.

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 : SANDIA

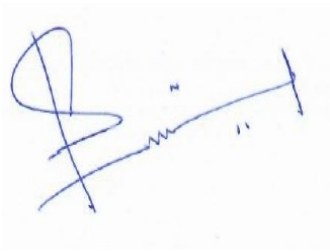
Stamp :



Patient 's signature{Parent : if minor}

Date : 04-Jul-2025

Signature :



Date : 04-Jul-2025