

Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name : FETHI ACHI
Card No : I040-029-121180791-01
Policy Holder : FETHI ACHI

Service Date :08-Jul-2025

Network

: Green

Health Provider :CITICARE MEDICAL CENTER LLC

Direct Access SP - YES

Doctor's Name :SANDIA

Payer Name : UNION INSURANCE COMPANY

Co-Insurance :

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

TPA : E CARE - Blue Network

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

Remarks :

Gender : Male

Date Of Birth : 17-Nov-1999

Patient's Tel No : 0581127489

☐ Acute ☐ Pre-existing and chronic ☐ Maternity

Chief Complaints : Came for routine checkup Pt complaints of tiredness and acne over the face **Duration:** and nape of neck Food habits include red meat, junk food On examination nodular acne present,Vit D3 22.9 Known hypothyroidism on medication

Vitals:Temp : 36.6 Bp :132 Pulse :72 Resp :18**Clinical Findings:**

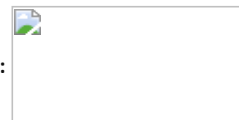
Diagnosis: R53.82 - Chronic fatigue, unspecified,R53.81 - Other malaise,L70.0 - Acne vulgaris,E03.9 - Hypothyroidism, unspecified,

Date of Onset :08/04/2025**Requested Investigations:** 9, Consultation GP **Estimated Cost** :**Prescriptions:** 5915-640420-0061 - (VITAMIN D3 (CHOLECALCIFEROL) : 10000 IU) CAPSULES, **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 :** Jul-2025**Signature :****Date** : 08-Jul-2025