Administrative

MEDICAL CLAIM FORM

:KEERTHANA

Claim Ref:

Patient

: VIJAY DAYAL SINGH

Service Date :12-Jul-2025

: Green

Name

Health :CITICARE MEDICAL CENTER LLC

Card No

Provider

Policy Holder: VIJAY DAYAL SINGH

: 1040-029-120878619-01

Doctor's

Direct Access SP - YES

Payer Name : UNION INSURANCE COMPANY

Name

Co-Insurance

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

Network

TPA

Signature:

: E CARE - Blue Network

: 22-08-2024 To 21-08-2025

Validity

Remarks

: Male Gender

Date Of Birth	: 23-Oct-1998
Patient's Tel	. 0567284544

Acute	Pre-existing and c	hronic		Maternity	
Chief Complaints	: PC Tiredness, dizziness, pain o	over back o	of head since 5 days Pt also cpmpl	aints Duration:	
of nausea since 5	days On examination Pt consc	ious and o	riented He is working as chef and		
•		visit He w	as serially monitoring bp for the la	ast 5	
days and was hig					
/itals:Temp: 36.	4 Bp :160 Pulse :80 Resp :18				
Clinical Findings:					
•	ssential (primary) hypertensio plesterolemia,K76.0 - Fatty (cha	•		6.0 - Dehydration,E78.01 - Date of :13 Onset	/02/2025
10 MG/2ML) SOL	UTION FOR INJECTION,96360,	HYDRATIO	3-1021, PREMOSAN -(METOCLOPF N IV INFUSION INIT,0439-152905- DIAG INJ SC/IM,80061, LIPID PANE	1001, Cost	
•	03-397801-1171 - (DOMPERID INE : 5MG) TABLETS,	ONE (AS M	1ALEATE) : 10 MG) TABLETS,0095-:	115904- Estimated : Cost	
MEDICAL PRACTITIONER DECLARATION :			PATIENT'S 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.		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.			
			د. کیرثانا راني بادیبورایل ثارا Dr. Keerthana Rani Padippurayil Thara	Patient 's signature{Parent :	13- Date : Jul-

Date : 13-Jul-2025