Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	**: LAKAI MITRA JATINDRA MITRA MITRA**
Card No	**: I040-029-113719086-01**
Policy Holder	**: LAKAI MITRA JATINDRA MITRA MITRA**
Payer Name	**: UNION INSURANCE COMPANY**
TPA	**: E CARE - Blue Network**
Validity	**: 02-01-2025** To **01-01-2026**
Gender	**: Male**
Date Of Birth	**: 05-Mar-1982**
Patient's Tel No	**: 508842935**

Service Date :13-Jul-2025 **Network** : Green

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

Doctor's Name :KEERTHANA

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 : PC: dry itchy scalp HOPC: Pt complaints of itching over the scalp since the last 2 months O\E dry scalp with white powdery appearance **Duration:**

Vitals: Temp : 36.6 Bp :100 Pulse :92 Resp :18

Clinical Findings:

Diagnosis: L23.9 - Allergic contact dermatitis, unspecified cause,L29.9 - Pruritus, unspecified, **Date of Onset** :13/20/2025

Requested Investigations: 9, Consultation GP,85004, BLOOD COUNT AUTOMATED DIFFERENTIAL WBC COUNT,86140, C REACTIVE PROTEIN,0005-111805-1021, CHLOROHISTOL 10MG-(CHLORPHENIRAMINE MALEATE : 10 MG/ML) SOLUTION FOR INJECTION,96372, THER/PROPH/DIAG INJ SC/IM **Estimated Cost :**

Prescriptions: 0005-119803-1171 - (PREDNISOLONE : 20 MG) TABLETS,7250-213601-4751 - (HYDROCORTISONE 17- BUTYRATE : 0.1%) SCALP LOTION, **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.

Dr's Name : KEERTHANA **Stamp :**

د. كيرثانا راني بادبيورايل ثارا
Dr. Keerthana Rani Padippurayil Thara
General Practitioner
License No.: 37864046-001
مركز سيتيكير الطبي ذ م م
CITICARE MEDICAL CENTER LLC

Signature : 

Date : 13-Jul-2025

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.

Patient 's signature{Parent if minor} :  **Date :** 13-Jul-2025