Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	: **ANISHA ANIL KATTIKKARAN**	**Service Date**	**:27-Jul-2025**
Card No	: **I040-029-121542378-01**	**Health Provider**	**:CITICARE MEDICAL CENTER LLC**
Policy Holder	: **ANISHA ANIL KATTIKKARAN**	**Doctor's Name**	**:KEERTHANA**
Payer Name	: **UNION INSURANCE COMPANY**	**Co-Insurance**	:
TPA	: **E CARE - Blue Network**	**Remarks**	:
Validity	: **02-01-2025** To **01-01-2026**		
Gender	: **Female**		
Date Of Birth	: **29-Sep-1999**		
Patient's Tel No	: **0553685056**		

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 : PC COUGH,RUNNING NOSE,BODYPAIN,NASAL BLOCK HOPC pt presented with complaints of ,running nose,nasal block since one week.She also has bodypain,cough and sorethroat that started yesterday No history of drug allergy Nil comorbs O\E Chest clear Tonsils erythematous **Duration:**

Vitals: Temp : 36 Bp :110 Pulse :78 Resp :18

Clinical Findings:

Diagnosis: J02.9 - Acute pharyngitis, unspecified,J30.89 - Other allergic rhinitis,R50.9 - Fever, unspecified,R05 - Cough, **Date of Onset** :27/19/2025

Requested Investigations: 0005-149902-1021, CLOFEN -(DICLOFENAC SODIUM : 75 MG/3ML) SOLUTION FOR INJECTION,0005-111805-1021, CHLOROHISTOL INJECTION,0188-135906-2441, PULMICORT-(BUDESONIDE : 0.5 MG/ML) SUSPENSION FOR NEBULIZATION,85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,86140, C REACTIVE PROTEIN,9, Consultation GP,96372, THER/PROPH/DIAG INJ SC/IM,94640, AIRWAY INHALATION TREATMENT **Estimated Cost** :

Prescriptions: 6916-119814-0173 - (PREDNISOLONE : 10 MG) DISPERSIBLE TABLETS,0207-533801-1451 - (ESOMEPRAZOLE (AS MAGNESIUM) : 20 MG) CAPSULES (HARD GELATIN),0139-116207-1171 - (CLAVULANIC ACID : 125 MG) (AMOXICILLIN : 500 MG) TABLETS,0027-296201-1971 - (XYLOMETAZOLINE HCL (MENTHOL) : 0.1%) LIQUID FOR SPRAY (NASAL), **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 بادييورايل ثارا
Dr. Keerthana Rani Padippurayil Thara
General Practitioner
License No.: 37864046-001
مـركـز سيتيكير الطبي ذم م
CITICARE MEDICAL CENTER LLC

Signature :

Date : 27-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 : 27-Jul-2025