Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	**: RAJAMANI CHELLAYAN**	**Service Date**	**:15-Aug-2025** **Network** : Green
Card No	**: I040-029-113383351-01**	**Health Provider**	**:CITICARE MEDICAL CENTER LLC** **Direct Access SP - YES**
Policy Holder	**: RAJAMANI CHELLAYAN**	**Doctor's Name**	**:KEERTHANA**
Payer Name	**: UNION INSURANCE COMPANY**	**Co-Insurance**	
TPA	**: ECARE-EBP EBP Enhanced CLASIC**	**Remarks**	**:**
Validity	**: 13-01-2025** To **12-01-2026**		
Gender	**: Male**		
Date Of Birth	**: 06-Jun-1966**		
Patient's Tel No	**: 0556895440**		

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 : Came for dressing **Duration :**

Vitals: Temp : 36.7 Bp :127 Pulse :78 Resp :18

Clinical Findings:

Diagnosis: S01.81XA - Laceration w/o foreign body of oth part of head, init encntr,Z48.02 - Encounter for removal of sutures, **Date of Onset** :15/27/2025

Estimated Cost :

Requested Investigations: 15850, REMOVAL OF SUTURES

Estimated Cost :

Prescriptions:

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 باديبورايل ثارا
Dr. Keerthana Rani Padippurayil Thara
General Practitioner
License No.: 37864046-001
مـركـز سيتيكير الطبي ذم م
CITICARE MEDICAL CENTER LLC

Signature : **Date** : 15-Aug-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 :** 15-Aug-2025