Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	: **MONICA RAM DATT SHARMA**	**Service Date**	:**16-Aug-2025** **Network** : Green
Card No	: **I040-029-117518711-01**	**Health Provider**	:**CITICARE MEDICAL CENTER LLC** **Direct Access SP - YES**
Policy Holder	: **MONICA RAM DATT SHARMA**	**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	: **16-Mar-1995**		
Patient's Tel No	: **0509706442**		

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 followup URE pus cells 25-50 **Duration :**

Vitals:

Clinical Findings:

Diagnosis: N39.0 - Urinary tract infection, site not specified,R30.0 - Dysuria,N10 - Acute pyelonephritis,R10.30 - Lower abdominal pain, unspecified, **Date of Onset** :16/17/2025

Requested Investigations: 87086, CULTURE BACTERIAL QUANTTATIVE COLONY COUNT URINE,74400, UROGRAPHY IV W/WO KUB W/WO TOMOGRAPHY,9.01, Follow Up Consultation GP **Estimated Cost** :

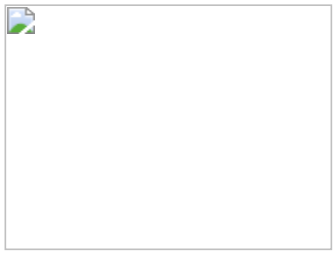
Prescriptions: **Estimated Cost** :

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

Signature :  **Date** : 16-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 :** 16-Aug-2025