Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	: **MONICA RAM DATT SHARMA**	**Service Date**	:**20-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 She is planning for pregnancy She have regular menstrual cycle O\E P\A soft non tender **Duration:**

Vitals: Temp : 36.8 Bp :112 Pulse :80 Resp :22

Clinical Findings:

Diagnosis: N39.0 - Urinary tract infection, site not specified,R30.0 - Dysuria,K29.00 - Acute gastritis without bleeding, **Date of Onset** :20/01/2025

Requested Investigations: 76700, Ultrasound, abdominal, real time with image documentation; complete,Pa001, GENARAL WELLNESS PACKEGE,76700, US EXAM ABDOM COMPLETE,9, Consultation GP **Estimated Cost** :

Prescriptions: 0207-533801-1451 - (ESOMEPRAZOLE (AS MAGNESIUM) : 20 MG) CAPSULES (HARD GELATIN),0095-187902-1451 - (NITROFURANTOIN : 100 MG) CAPSULES (HARD GELATIN), **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 ذ م م
CITICARE MEDICAL CENTER LLC

Signature : **Date** : 20-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 :** 20-Aug-2025