Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	**: HTET NAING . LIN**
Card No	**: I040-029-120590609-01**
Policy Holder	**: HTET NAING . LIN**
Payer Name	**: UNION INSURANCE COMPANY**
TPA	**: E CARE - Blue Network**
Validity	**: 14-03-2024** To **01-01-2025**
Gender	**: Male**
Date Of Birth	**: 11-Oct-1997**
Patient's Tel No	**: 0559467077**

Service Date :28-Aug-2024 **Network** : Green

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

Doctor's Name :AHSAN HUSSAIN

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: PAIN AT BACK 3 DAYS LIFT HEAVY OBJECTS **Duration :**

Vitals: Temp : 36.7 Bp :110 Pulse :78 Resp :18

Clinical Findings:

Diagnosis: M54.5 - Low back pain,M79.605 - Pain in left leg, **Date of Onset** : 28/24/2024

Requested Investigations: 0005-149902-1021, CLOFEN ,96372, THER/PROPH/DIAG INJ SC/IM,9, Consultation GP **Estimated Cost** :

Prescriptions: 4179-711202-0391 - (IBUPROFEN (AS L-ARGININE SALT) : 400 MG) FILM COATED TABLETS,2093-596002-0431 - (DICLOFENAC DIETHYLAMINE : 23.2 MG / G) GEL, **Estimated Cost** :

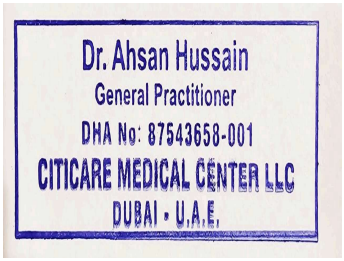
MEDICAL PRACTITIONER DECLARATION :

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.

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.

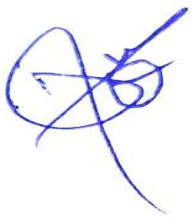
Dr's Name : AHSAN HUSSAIN **Stamp :**



Patient 's signature{Parent if minor} :

Date : 28-Aug-2024

Signature :



Date : 28-Aug-2024