Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	**: RAMESH CHANDRA PATIDAR**
Card No	**: I040-029-113722477-01**
Policy Holder	**: RAMESH CHANDRA PATIDAR**
Payer Name	**: UNION INSURANCE COMPANY**
TPA	**: E CARE - Blue Network**
Validity	**: 02-01-2024** To **01-01-2025**
Gender	**: Male**
Date Of Birth	**: 15-Jul-1978**
Patient's Tel No	**: 0563834759**

Service Date **:30-Nov-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: cough 29/11/2024 wheezing fever **Duration** **:**

Vitals: Temp : 37.5 Bp :150 Pulse :86 Resp :19

Clinical Findings:

Diagnosis: J20.9 - Acute bronchitis, unspecified,J45.991 - Cough variant asthma,R07.1 - Chest pain on breathing,R50.9 - Fever, unspecified, **Date of Onset** **:**30/10/2024

Requested Investigations: 0005-107704-0802, TRIAXONE I.V.-(CEFTRIAXONE : 1 G) POWDER FOR INJECTION,96365, THER/PROPH/DIAG IV INF INIT,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE,96372, THER/PROPH/DIAG INJ SC/IM,0188-135906-2441, PULMICORT,94640, AIRWAY INHALATION TREATMENT,9, Consultation GP **Estimated Cost** **:**

Prescriptions: 0005-134001-1172 - (BROMHEXINE HYDROCHLORIDE : 8 MG) TABLETS,0195-123701-0391 - (CETIRIZINE HCL : 10 MG) FILM COATED TABLETS,0005-114501-2481 - (AMBROXOL : 15 MG/5ML SYRUP (SUGAR FREE, **Estimated Cost** **:**

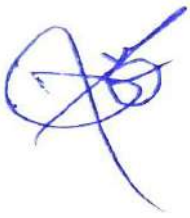
MEDICAL PRACTITIONER DECLARATION :

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 **:** AHSAN HUSSAIN

Stamp :

Signature :



Date **:** 30-Nov-2024

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 : 30-Nov-2024