MEDICAL CLAIM FORM

HealthCare Insurance Company
Claim Reference: CLM-2024-789456
Date Filed: January 15, 2025

PATIENT INFORMATION

Patient Name:	John Michael Smith
Date of Birth:	March 15, 1985
Policy Number:	POL-987654321
Contact Number:	+1-555-0123
Email:	john.smith@email.com

CLAIM DETAILS

Type of Service:	Outpatient Consultation
Date of Service:	January 10, 2025
Provider Name:	Dr. Sarah Johnson, MD
Hospital/Clinic:	City Medical Center
Diagnosis:	Acute Bronchitis (ICD-10: J20.9)
Treatment Provided:	Consultation, Chest X-Ray, Prescription
Total Amount Claimed:	$450.00
Insurance Coverage:	80%
Patient Responsibility:	$90.00

DECLARATION

I hereby declare that the information provided above is true and accurate to the best of my knowledge.

Signature: _____ Date: _____

GLOBAL TRUST BANK

123 Financial District
New York, NY 10004

CHEQUE DETAILS

Cheque Number:	CH-456789123
Account Number:	XXXX-XXXX-1234
Date Issued:	February 1, 2025
Payee:	John Michael Smith
Amount:	$1,500.00

BANK ACCOUNT DETAILS

Account Holder Name:	John Michael Smith
Account Type:	Savings Account
Bank Name:	Global Trust Bank
Branch:	Main Branch - New York
IFSC/Routing Number:	GTB000123456
SWIFT Code:	GTBNUS33XXX
Account Number:	1234567890123
Account Status:	Active

This is a computer-generated document. For verification, contact Global Trust Bank at 1-800-BANK-GTB

GOVERNMENT ID CARD

[PHOTO]

Signature: J.M. Smith

PERSONAL INFORMATION

Full Name:	JOHN MICHAEL SMITH
ID Number:	ID-987-654-321
Date of Birth:	15-MAR-1985
Gender:	Male
Blood Group:	O+
Address:	456 Oak Street, Apt 12B Springfield, IL 62701
Issue Date:	15-JAN-2023
Expiry Date:	15-JAN-2033

|||| |||| |||| |||| ||||

This document contains security features. Issued by Department of Motor Vehicles.

CITY MEDICAL CENTER

789 Healthcare Boulevard
Boston, MA 02101
Tel: (555) 987-6543

DISCHARGE SUMMARY

PATIENT INFORMATION

Name:	John Michael Smith
MRN:	MRN-123456789
Date of Birth:	March 15, 1985 (Age: 40)
Admission Date:	January 20, 2025
Discharge Date:	January 25, 2025
Length of Stay:	5 days
Attending Physician:	Dr. Sarah Johnson, MD

CLINICAL SUMMARY

Admission Diagnosis: Community Acquired Pneumonia (CAP)

Hospital Course:

Patient admitted with fever, cough, and shortness of breath. Chest X-ray confirmed right lower lobe pneumonia. Started on IV antibiotics (Ceftriaxone 1g daily). Patient showed gradual improvement with resolution of fever by day 3. Oxygen saturation improved to 96% on room air. Repeat chest X-ray showed improvement.

DISCHARGE INFORMATION

Condition at Discharge:	Stable, improved
Discharge Medications:	Amoxicillin 500mg TID x 7 days
	Acetaminophen 500mg PRN for pain
Follow-up:	Outpatient clinic in 1 week
Activity:	Gradual return to normal activities
Diet:	Regular diet, increase fluid intake

Digitally signed by: Dr. Sarah Johnson, MD
Date: January 25, 2025, 4:30 PM

Rx

Dr. Sarah Johnson, MD

Internal Medicine Specialist
City Medical Center, Suite 304
Boston, MA 02101
License: MD-987654 | Phone: (555) 123-4567

PATIENT INFORMATION

Name: John Michael Smith

Age: 40 years

Date: February 1, 2025

Patient ID: PAT-789456

PRESCRIPTION

1. Amoxicillin 500mg

Dosage: 1 capsule three times daily
Duration: 7 days
Instructions: Take with food

2. Acetaminophen 500mg

Dosage: 1-2 tablets every 6 hours as needed
Duration: As required
Instructions: Do not exceed 8 tablets in 24 hours

3. Cetirizine 10mg

Dosage: 1 tablet once daily at bedtime
Duration: 5 days
Instructions: May cause drowsiness

GENERAL INSTRUCTIONS:

- Complete the full course of antibiotics even if feeling better
- Drink plenty of fluids (8-10 glasses of water daily)
- Rest adequately
- Follow up if symptoms worsen or do not improve in 3 days

Doctor's Signature: _____

Date: Feb 1, 2025

This prescription is valid for 30 days from the date of issue. Not valid without doctor's signature.

PATHOLOGY LABORATORY

Advanced Diagnostics Center
456 Laboratory Lane
Boston, MA 02102
NABL Accredited | ISO 9001:2015

LABORATORY REPORT

Patient Name:	John Michael Smith	Report ID:	LAB-2025-001234
Age/Gender:	40 Years / Male	Collection Date:	Jan 30, 2025
Ref. by:	Dr. Sarah Johnson	Report Date:	Jan 31, 2025
Patient ID:	PAT-789456	Sample Type:	Blood - Serum

COMPLETE BLOOD COUNT (CBC)

TEST	RESULT	UNIT	REFERENCE RANGE
Hemoglobin	14.2	g/dL	13.0 - 17.0
RBC Count	4.8	million/µL	4.5 - 5.5
WBC Count	7.5	thousand/µL	4.0 - 11.0
Platelet Count	250	thousand/µL	150 - 400
Hematocrit	42.5	%	40 - 50
MCV	88	fL	80 - 100
MCH	29.6	pg	27 - 33
MCHC	33.4	g/dL	32 - 36

DIFFERENTIAL COUNT

Neutrophils	62	%	40 - 70
Lymphocytes	30	%	20 - 40
Monocytes	6	%	2 - 10
Eosinophils	2	%	1 - 6
Basophils	0.5	%	0 - 2

COMMENTS:

All parameters are within normal limits.

Pathologist: Dr. Robert Chen, MD

Lab Technician: Mary Williams

**** End of Report *** | This is a computer-generated report. Results are verified by qualified personnel.*

CASH RECEIPT

City Medical Center
789 Healthcare Boulevard
Boston, MA 02101

Receipt No: RCP-2025-456789

Date: February 1, 2025

Time: 10:45 AM

Received from: John Michael Smith

Patient ID: PAT-789456

Description	Amount
Consultation Fee - Dr. Sarah Johnson	$150.00
Laboratory Tests (CBC, Blood Sugar)	$80.00
Medications (Prescription)	$45.00
Service Charges	$10.00

TOTAL AMOUNT PAID: **$285.00**

Payment Method: Cash

Thank you for choosing City Medical Center
For any queries, please contact: billing@citymedical.com

Cashier Signature: _____ [OFFICIAL STAMP]

PATIENT REGISTRATION FORM

City Medical Center
789 Healthcare Boulevard
Boston, MA 02101

---

*Please fill out this form completely. All fields marked with * are mandatory.*

PERSONAL INFORMATION

* First Name: _____ * Last Name: _____

* Date of Birth: ____/____/_____ Gender: ■ Male ■ Female ■ Other

* Social Security Number: _____-_____-_____

* Phone Number: (_____)_____ Email: _____

* Address Line 1: _____

Address Line 2: _____

* City: _____ * State: _____ * ZIP Code: _____

EMERGENCY CONTACT

* Contact Name: _____

* Relationship: _____ * Phone: (_____)_____

INSURANCE INFORMATION

Insurance Provider: _____

Policy Number: _____ Group Number: _____

Policy Holder Name: _____ Relationship: _____

MEDICAL HISTORY

Do you have any known allergies? ■ Yes ■ No

If yes, please list: _____

Current Medications: _____

_____

CONSENT AND AUTHORIZATION

I hereby consent to medical treatment and authorize City Medical Center to release my medical information as necessary for treatment, payment, and healthcare operations. I certify that the information provided above is accurate and complete to the best of my knowledge.

Patient Signature: _____ Date: _____

ITEMIZED HOSPITAL BILL

City Medical Center
789 Healthcare Boulevard
Boston, MA 02101
Phone: (555) 987-6543

BILLING INFORMATION

Bill Number:	BILL-2025-789456
Bill Date:	February 1, 2025
Patient Name:	John Michael Smith
Patient ID:	PAT-789456
Admission Date:	January 20, 2025
Discharge Date:	January 25, 2025
Insurance:	HealthCare Insurance Co.

ITEMIZED CHARGES

DATE	DESCRIPTION	QTY	RATE	AMOUNT
01/20/25	Room Charges - Semi-Private (5 days)	5	$200.00	$1,000.00
01/20/25	Admission Fee	1	$150.00	$150.00
01/20/25	Emergency Room Services	1	$500.00	$500.00
01/20/25	Physician Consultation - Dr. Sarah Johnson	5	$150.00	$750.00
01/20/25	Chest X-Ray	2	$120.00	$240.00
01/21/25	CT Scan - Chest	1	$800.00	$800.00
01/20/25	Complete Blood Count (CBC)	3	$45.00	$135.00
01/21/25	Blood Culture Test	2	$80.00	$160.00
01/22/25	Arterial Blood Gas Analysis	1	$95.00	$95.00
01/20/25	IV Fluids - Normal Saline	10	$25.00	$250.00
01/20/25	Injection - Ceftriaxone 1g	5	$30.00	$150.00
01/21/25	Injection - Paracetamol	6	$8.00	$48.00
01/22/25	Nebulization Treatment	4	$35.00	$140.00
01/20/25	Oxygen Therapy (per hour)	48	$5.00	$240.00
01/20/25	Nursing Care (per day)	5	$100.00	$500.00
01/20/25	ICU Monitoring Equipment	2	$200.00	$400.00
01/23/25	Physiotherapy Session	3	$60.00	$180.00
01/20/25	Medical Supplies & Consumables	1	$250.00	$250.00
01/20/25	Laboratory Processing Fee	1	$75.00	$75.00
01/20/25	Pharmacy Dispensing Fee	1	$50.00	$50.00

Subtotal:	**$6,113.00**
Tax (5%):	**$305.65**
Total Amount:	**$6,418.65**
Insurance Payment (80%):	**-$5,134.92**
Patient Responsibility (20%):	**$1,283.73**

PHARMACY & OUTPATIENT BILL

City Medical Center
Outpatient Pharmacy Department
Boston, MA 02101

BILLING DETAILS

Invoice Number:	INV-2025-123789
Date:	February 2, 2025
Patient:	John Michael Smith (PAT-789456)
Prescribed by:	Dr. Sarah Johnson, MD

MEDICATION DETAILS

ITEM	DOSAGE	QTY	PRICE	TOTAL
Amoxicillin 500mg Capsules	500mg TID	21	$1.50	$31.50
Acetaminophen 500mg Tablets	500mg PRN	20	$0.80	$16.00
Cetirizine 10mg Tablets	10mg OD	10	$0.90	$9.00
Omeprazole 20mg Capsules	20mg BD	14	$1.20	$16.80
Albuterol Inhaler	2 puffs	1	$35.00	$35.00
Vitamin D3 1000 IU	1 tab daily	30	$0.40	$12.00
Probiotic Capsules	1 cap daily	30	$0.85	$25.50
Saline Nasal Spray	As needed	1	$8.50	$8.50
Antiseptic Mouthwash 250ml	Twice daily	1	$12.00	$12.00
Digital Thermometer	N/A	1	$15.00	$15.00

ADDITIONAL SERVICES

Medication Counseling	-	1	$25.00	$25.00
Home Delivery Service	-	1	$10.00	$10.00

Subtotal:	**$216.30**
Discount (10%):	**-$21.63**
Tax (6%):	**$11.68**
TOTAL DUE:	**$206.35**

Payment Method: Cash / Credit Card / Insurance

Thank you for choosing City Medical Center Pharmacy!

COMPREHENSIVE METABOLIC PANEL

Advanced Diagnostics Center
456 Laboratory Lane
Boston, MA 02102
CLIA Certified | CAP Accredited

Patient:	John Michael Smith	Report ID:	LAB-2025-001567
DOB:	03/15/1985 (40Y/M)	Collected:	Jan 31, 2025 8:00 AM
Physician:	Dr. Sarah Johnson	Reported:	Jan 31, 2025 2:30 PM
MRN:	MRN-123456789	Specimen:	Serum

TEST RESULTS

TEST NAME	RESULT	UNIT	REFERENCE RANGE	FLAG
GLUCOSE METABOLISM				
Glucose, Fasting	95	mg/dL	70 - 100	
Hemoglobin A1c	5.4	%	< 5.7	
KIDNEY FUNCTION				
Blood Urea Nitrogen (BUN)	18	mg/dL	7 - 20	
Creatinine	1.0	mg/dL	0.7 - 1.3	
eGFR	92	mL/min/1.73m²	> 60	
BUN/Creatinine Ratio	18		10 - 20	
LIVER FUNCTION				
Total Protein	7.2	g/dL	6.0 - 8.3	
Albumin	4.5	g/dL	3.5 - 5.5	
Globulin	2.7	g/dL	2.0 - 3.5	
A/G Ratio	1.67		1.0 - 2.5	
Total Bilirubin	0.8	mg/dL	0.1 - 1.2	
AST (SGOT)	28	U/L	0 - 40	
ALT (SGPT)	32	U/L	0 - 41	
Alkaline Phosphatase	75	U/L	30 - 120	
ELECTROLYTES				
Sodium	140	mmol/L	136 - 145	
Potassium	4.2	mmol/L	3.5 - 5.1	
Chloride	102	mmol/L	98 - 107	
CO2 (Bicarbonate)	25	mmol/L	22 - 29	
Calcium	9.5	mg/dL	8.5 - 10.5	

INTERPRETATION:
All parameters are within normal limits. No abnormalities detected.

*** End of Report *** This report is electronically verified and does not require a signature.

Reviewed by: Dr. Robert Chen, MD, FCAP — Medical Director

LIPID PANEL & THYROID FUNCTION

Advanced Diagnostics Center
456 Laboratory Lane
Boston, MA 02102

Patient: John Michael Smith
Age/Sex: 40 Years / Male
Physician: Dr. Sarah Johnson

Report ID: LAB-2025-001890
Collected: Feb 1, 2025
Reported: Feb 1, 2025

LIPID PANEL (FASTING)

TEST NAME	RESULT	UNIT	REFERENCE RANGE	FLAG
Total Cholesterol	195	mg/dL	< 200 Desirable	
Triglycerides	145	mg/dL	< 150 Normal	
HDL Cholesterol	52	mg/dL	> 40 Normal	
LDL Cholesterol (calc)	114	mg/dL	< 100 Optimal	**BORDERLINE**
VLDL Cholesterol	29	mg/dL	5 - 40	
Non-HDL Cholesterol	143	mg/dL	< 130 Optimal	**BORDERLINE**
Cholesterol/HDL Ratio	3.75		< 5.0 Optimal	

LIPID PANEL INTERPRETATION:

- LDL cholesterol is borderline high. Lifestyle modifications recommended.
- Consider dietary changes: reduce saturated fats, increase fiber intake.
- Regular exercise (30 min daily) may help improve lipid profile.
- Repeat testing in 3 months to monitor progress.

THYROID FUNCTION TESTS

TEST NAME	RESULT	UNIT	REFERENCE RANGE	FLAG
TSH	2.5	µIU/mL	0.4 - 4.0	
Free T4 (FT4)	1.2	ng/dL	0.8 - 1.8	
Free T3 (FT3)	3.1	pg/mL	2.3 - 4.2	
Anti-TPO Antibodies	15	IU/mL	< 35	

THYROID FUNCTION INTERPRETATION:

- Thyroid function is within normal limits.
- No evidence of hypothyroidism or hyperthyroidism.

VITAMIN D & OTHER MARKERS

TEST NAME	RESULT	UNIT	REFERENCE RANGE	FLAG
Vitamin D (25-OH)	28	ng/mL	30 - 100 Optimal	**LOW**
Vitamin B12	450	pg/mL	200 - 900	
Folate	12.5	ng/mL	> 3.0	
*** End of Report ***				
Iron	85	µg/dL	60 - 170	
Ferritin	125	ng/mL	30 - 400	

INFORMED CONSENT FORM

City Medical Center
789 Healthcare Boulevard
Boston, MA 02101

PATIENT INFORMATION

Patient Name: John Michael Smith

Date of Birth: March 15, 1985

Medical Record Number: MRN-123456789

Date: February 3, 2025

PROCEDURE/TREATMENT INFORMATION

Proposed Procedure: Endoscopy (Upper GI)

Performing Physician: Dr. Sarah Johnson, MD

Scheduled Date: February 15, 2025

CONSENT STATEMENT

I hereby give my consent to undergo the above-mentioned procedure. My physician has explained to me in terms that I understand:

1. The nature and purpose of the procedure
2. The potential benefits and expected outcomes
3. The possible risks and complications, including but not limited to:
   - Bleeding or infection at the procedure site
   - Adverse reactions to anesthesia or sedation
   - Perforation or damage to internal organs (rare)
   - Respiratory complications

4. Alternative treatment options available
5. The consequences of not undergoing this procedure

I understand that the practice of medicine is not an exact science and that no guarantees have been made regarding the outcome of this procedure. I have had the opportunity to ask questions and all my questions have been answered to my satisfaction.

I authorize the medical staff to perform any additional procedures deemed necessary during the course of this treatment. I consent to the administration of anesthesia or sedation as required.

I understand that I have the right to withdraw this consent at any time before the procedure.

ACKNOWLEDGMENT

■ I have read and understood this consent form

■ I have received a copy of this consent form

■ All my questions have been answered

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Physician Signature: _____ Date: _____

CITY MEDICAL CENTER

789 Healthcare Boulevard
Boston, MA 02101
Phone: (555) 987-6543
Email: appointments@citymedical.com

Date: February 3, 2025

Mr. John Michael Smith
456 Oak Street, Apt 12B
Springfield, IL 62701

Subject: Appointment Confirmation

Dear Mr. Smith,

This letter is to confirm your upcoming appointment with our medical facility.

Appointment Details:
• Date: February 15, 2025
• Time: 10:00 AM
• Department: Gastroenterology
• Physician: Dr. Sarah Johnson, MD
• Location: Building A, 3rd Floor, Suite 304
• Procedure: Upper GI Endoscopy

Important Instructions:

Before Your Appointment:
• Fast for at least 8 hours prior to the procedure (no food or drink after midnight)
• Stop taking blood thinners 3 days before (consult with your physician)
• Bring your insurance card and photo ID
• Arrive 30 minutes early to complete registration

After the Procedure:
• You will need someone to drive you home (sedation will be administered)
• Plan to rest for the remainder of the day
• Resume normal diet gradually as tolerated

Please bring the following:
1. Current medication list
2. Signed consent form (attached)
3. Insurance authorization (if applicable)
4. Any previous medical records related to this condition

If you need to reschedule or cancel this appointment, please contact us at least 24 hours in advance at (555) 987-6543 or email appointments@citymedical.com.

This is an automatically generated letter. Please retain for your records.
We look forward to serving you.

Sincerely,

INSURANCE VERIFICATION FORM

City Medical Center
Insurance Verification Department

VERIFICATION DETAILS

Verification Date: February 3, 2025 Time: 9:30 AM

Verified By: Mary Johnson, Insurance Coordinator

Reference Number: VER-2025-456789

PATIENT INFORMATION

Name:	John Michael Smith
Date of Birth:	March 15, 1985
Patient ID:	PAT-789456
Contact:	+1-555-0123

INSURANCE INFORMATION

Insurance Provider:	HealthCare Insurance Company
Policy Number:	POL-987654321
Group Number:	GRP-12345
Subscriber Name:	John Michael Smith
Relationship:	Self
Effective Date:	January 1, 2024
Policy Status:	ACTIVE

COVERAGE VERIFICATION

Benefit Type	Coverage	Status
Inpatient Hospital	80% after deductible	ACTIVE
Outpatient Services	80% after deductible	ACTIVE
Emergency Services	80% after deductible	ACTIVE
Preventive Care	100% coverage	ACTIVE
Prescription Drugs	Tier-based copay	ACTIVE
Laboratory Services	80% after deductible	ACTIVE
Diagnostic Imaging	80% after deductible	ACTIVE

DEDUCTIBLE & OUT-OF-POCKET INFORMATION

Annual Deductible:	$1,500.00	Met:	$450.00	Remaining:	$1,050.00
Out-of-Pocket Max:	$6,000.00	Met:	$890.00	Remaining:	$5,110.00

This verification is not a guarantee of payment. Final payment is subject to patient eligibility at time of service.

PRIOR AUTHORIZATION STATUS

Procedure: Upper GI Endoscopy

MEDICAL HISTORY QUESTIONNAIRE

City Medical Center

Please complete this form to the best of your ability. This information helps us provide better care.

PATIENT INFORMATION

Name: John Michael Smith
Date: Feb 3, 2025
DOB: March 15, 1985
Age: 40

PAST MEDICAL CONDITIONS

Please check any conditions you have or have had:

■ Diabetes
■ High Blood Pressure
■ Asthma
■ Heart Disease
■ Stroke
■ Cancer
■ Thyroid Problems
■ Kidney Disease
■ Liver Disease
■ Arthritis
■ Seasonal Allergies
■ Depression/Anxiety
■ COPD
■ Sleep Apnea
■ Gastric Reflux (GERD)
■ Other: _____

SURGICAL HISTORY

Have you had any surgeries? ■ Yes ■ No

If yes, please list:

1. Appendectomy - 2010
2. _____

CURRENT MEDICATIONS

Please list all medications you are currently taking (including over-the-counter):

1. Albuterol Inhaler - 2 puffs as needed for asthma
2. Cetirizine 10mg - once daily for allergies
3. Multivitamin - once daily
4. _____

ALLERGIES

Do you have any drug allergies? ■ Yes ■ No

If yes, please list the medication and reaction:

Penicillin - Causes rash and itching

FAMILY MEDICAL HISTORY

Please indicate if any immediate family members have had:

■ Heart Disease (Father)
■ Diabetes (Mother)
■ Cancer (specify): _____
■ Stroke
■ Mental Health Disorders

LIFESTYLE INFORMATION

Do you smoke? ■ Yes ■ No ■ Former smoker

Dr. Emily Roberts, MD
Family Medicine
Community Health Clinic
123 Main Street, Boston, MA 02101
Phone: (555) 123-4567 | Fax: (555) 123-4568

Date: February 3, 2025

To:
Dr. Sarah Johnson, MD
Gastroenterology Department
City Medical Center
789 Healthcare Boulevard, Boston, MA 02101

RE: Patient Referral - John Michael Smith (DOB: 03/15/1985)

Dear Dr. Johnson,

I am writing to refer my patient, John Michael Smith, to your care for evaluation and management of persistent upper gastrointestinal symptoms.

Chief Complaint:
Mr. Smith is a 40-year-old male who presents with a 3-month history of intermittent epigastric pain, heartburn, and occasional nausea. Symptoms are worse after meals and at night when lying down.

Relevant Medical History:
• No significant past medical history
• Previous appendectomy in 2010
• No known drug allergies except Penicillin (rash)
• Non-smoker, occasional alcohol use
• Family history: Father with heart disease, Mother with diabetes

Current Medications:
• Over-the-counter antacids (Tums) as needed
• Albuterol inhaler for mild asthma (rarely used)

Physical Examination:
• Vitals: BP 128/82, HR 72, Temp 98.6°F
• Abdomen: Soft, mild epigastric tenderness, no guarding or rebound
• No palpable masses

Diagnostic Workup Completed:
• H. pylori breath test: Negative
• Complete blood count: Within normal limits
• Comprehensive metabolic panel: Normal liver and kidney function

Treatment to Date:
• Trial of Omeprazole 20mg daily for 4 weeks with minimal improvement
• Dietary modifications recommended

Reason for Referral:
Given the persistence of symptoms despite initial treatment and the need for further evaluation, I would appreciate your expert opinion. I suspect the patient may benefit from an upper GI endoscopy to rule out peptic ulcer disease, gastritis, or other pathology.

I have discussed this referral with Mr. Smith and he is agreeable to the consultation. Please let me know if you need any additional information. I look forward to your recommendations regarding further management.

Thank you for your time and expertise.

Sincerely,

Dr. Emily Roberts, MD
Board Certified in Family Medicine

CC: Patient Medical Record