Reimbursement claim form

This claim form is not an admission of liability.

Please use a separate claim form for each separate visit to the doctor.

Date Received: *Select Date*

Prior Approval No

Dear Doctor, we thank you for filling in medical sections B, C and D of this claim form and for signing, dating and stamping it. Dear Member, we thank you for completing all other sections of this claim form and for signing and dating it. All fields on the front page are compulsory. We thank you in advance for your cooperation which will enable fast and accurate processing.

A. Administrative

Membership No : 13/XP/50530/1/43/E/0 Group Name/ Company Name : CITICARE MEDICAL CENTER LLC

Patient DOB: 30-Oct-1990 Gender : Female Patient Name : RACHELLE MAROUN BASSILI

Policy/ Group No.#: Plan : Patient Phone : 0509765667

Date Of Treatment : 03-Aug-2024 Admission Date: 03-Aug-2024 Discharge Date : 03-Aug-2024

Email Address :

B. Medical Section

Symptoms Presented

PC: throat pain, generalized body pains, joint pains, and weakness.

Duration: 2days

Fever started today.

Temp at presentation is 39.1 degrees

Date the patient first became aware of any signs or symptoms for this condition:
Select Date

Date on which the patient first presented to any doctor for this condition::
Select Date

Medical Condition/ Diagnosis:

Date	Doctor	ICD Code	Diagnosis	Notes
03-Aug-2024	Enomen Goodluck	K29.00	Acute gastritis without bleeding	
03-Aug-2024	Enomen Goodluck	M79.10	Myalgia, unspecified site	
03-Aug-2024	Enomen Goodluck	R50.9	Fever, unspecified	
03-Aug-2024	Enomen Goodluck	J02.9	Acute pharyngitis, unspecified	
03-Aug-2024	Enomen Goodluck	J03.90	Acute tonsillitis, unspecified	

Investigations((Describe necessary investigations requested to define the diagnosis):

Start Time	End Time	CPT Code	Treatment	Teeth No	Surface	Notes
00:00:00	00:00:00	85025	COMPLETE BLOOD COUNT (CBC) BLOOD	NA	NA	
00:00:00	00:00:00	86140	C-REACTIVE PROTEIN (CRP)	NA	NA	
00:00:00	00:00:00	96365	Intravenous infusion for therapy prophylaxis or diagnosis (specify substance or drug) initial up to	NA	NA	
00:00:00	00:00:00	0195-107704-0801	CEFTRIAXONE-TABUK IV	NA	NA	IV infusion over 30mins

Start Time	End Time	CPT Code	Treatment	Teeth No	Surface	Notes
00:00:00	00:00:00	0125-122107-1022	DEXAMETHASONE SODIUM PHOSPHATE-(DEXAMETHASONE : 4 MG/ML) SOLUTION FOR INJECTION	NA	NA	IV push
00:00:00	00:00:00	0005-174202-0781	RISEK 40MG	NA	NA	IV push
00:00:00	00:00:00	0005-150403-1021	PREMOSAN -(METOCLOPRAMIDE : 10 MG/2ML) SOLUTION FOR INJECTION	NA	NA	IV push
00:00:00	00:00:00	96374	Therapeutic prophylactic or diagnostic injection (specify substance or drug) intravenous push single	NA	NA	
00:00:00	00:00:00	96375	Therapeutic prophylactic or diagnostic injection (specify substance or drug) each additional sequent	NA	NA	
00:00:00	00:00:00	96372	Therapeutic prophylactic or diagnostic injection (specify substance or drug) subcutaneous or intramu	NA	NA	
00:00:00	00:00:00	0005-149902-1021	CLOFEN	NA	NA	IM stat
00:00:00	00:00:00	9	GP Consultation	NA	NA	

C. Treatments Advised:

Drugs:

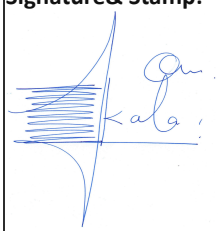
Generic/Dose/Form	Instructions	Duration	Quantity	Refill
GUPISONE 5MG / (PREDNISOLONE : 20 MG) TABLETS PREDNISOLONE [20 MG] / TABLETS (20S, BLISTER PACK) / Tablets	Take 2Tablets 1 Time(s) per Day For 7 Day(s) after meal	7	14	
FLUTAB / (DIPHENHYDRAMINE : 25 MG) (PARACETAMOL : 500 MG) (PSEUDOEPHEDRINE : 30 MG) FILM COATED TABLETS ORAL / FILM COATED TABLETS (20S, BLISTER PACK) / Tablets	Take 1Tablets 2 Time(s) per Day For 10 Day(s) after meal	10	20	
NEXIUM / (ESOMEPRAZOLE : 20 MG) FILM COATED TABLETS ORAL / FILM COATED TABLETS (14S, BLISTER PACK) / Tablets	Take 1Tablets 2 Time(s) per Day For 7 Day(s) after meal	7	14	
MAXIGESIC / (IBUPROFEN : 150 MG) (PARACETAMOL : 500 MG) FILM COATED TABLETS ORAL / FILM COATED TABLETS (16S, BLISTER) / Tablets	Take 2Tablets 2 Time(s) per Day For 4 Day(s) after meal	4	16	
AUGMENTIN 1G / (CLAVULANIC ACID : 125 MG) (AMOXICILLIN : 875 MG) TABLETS ORAL / TABLETS (14S, BLISTER PACK) / Tablets	Take 1Tablets 2 Time(s) per Day For 7 Day(s) after meal	7	14	

Procedure(Please give details of medical procedures if any):

D. Further Treatment Plan

E. Other Issuer Details :

Is the Treatment Accident Related ? ○ Yes ○ No	Is it covered under another insurance policy? ○ Yes ○ No

Patient Declaration	Medical practitioner declaration
I confirm I am the patient, patient's parent or guardian (if patient under 16 years of age) and wish to claim and declare that all the particulars given above are to the best of my knowledge true and correct. I hereby consent to and authorise the medical practitioner involved in the patient's care to discuss treatment details and discharge arrangements with and to AXA Insurance. I agree that a copy of this consent shall have the validity of the original.	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. **Name :** Enomen Goodluck
Signature : 	**Signature& Stamp:** 

Dr. Enomen Goodluck Ekata
General Practitioner
DHA No: 28040827-001
CITICARE MEDICAL CENTER LLC
DUBAI - U.A.E.

03-Aug-2024

F. Administrative specific to reimbursement claims

Amount Claimed: Please ensure that the amount claimed here is supported by original invoices and prescription

Cheque beneficiary name: (IN CAPITAL LETTERS)

Payment will be made in the currency defined in your plan unless we agreed otherwise in writing. In which currency was the treatment originally billed?

Member's and Patient Details : Patient Name and Address:

Telephone : Fax :

Address to which payment should be sent if different from above:

G. Medical Provider Details:

Name of medical Provider: CITICARE MEDICAL CENTER LLC Address : Al salam Building, Al Barsha South, Arjan Near Miracle Garden, Dubai, United Arab Emirates. Telephone : 047700948 fax : 042974343

H. If you are claiming for treatment received outside your area of cover, please answer the following questions:

(a). Country where the treatment took place

(b). The reason for the patient being abroad

(c). Date of departure and return to own area of cover: From : *Select Date* to *Select Date*

Are you claiming cash benefit for in-patient treatment? Please tick ○ Yes ○ No

If Yes, please enclose a hospital certificate confirming the dates of stay:

I. Payment details for bank transfer:

Bank Account Number :

Bank Name :

Bank Address :

Beneficiary Name:

Bank Sort/Swift Code :

AXA Use only

Batch No : Batch Opening Date: *Select Date*