Date	Doctor	Location	Quality	Severity	Duration	Timing	Context	Modifying Factor	Symptoms	
_		I	0	C	<b>.</b>	<b>-</b> · ·	_			
History of present	t illness									
restless										
oe chest is conges	sted no added sound:	s								
co nasal blockage	e productive cough	pain in throa	it 15th dec	2024						
Chief complaint										
If Pregnant: L.M.F	P. Date Nature of con	ception $\bigcirc$	Natural (	Assisted						
Type of visit $\Box$ O	Outpatient 🗆 Inpatio	ent If 🗆 Eme	ergency 🗆	Maternity	☐ Dental	Optical				
Medical Section										
Date of treatmen	of treatment 18-Dec-2024			Patient Gender			O Male 🤇	○ Male 🥑 Female		
Patient name	YASEMIN C	DZDERE		Provider name CITICA			CITICARE N	RE MEDICAL CENTER LLC		
Policy number	licy number 13/XC/36001/0/68/E/0 Me				Membership number					
Administrative Se	ection									
AXA						DirectThsclaimf	iorm Billingis notai	n admission Claim of Formliability		

# Clinical findings/other conditions

### Past medical history

Details of trauma - if applicable (where, when & how) Work Related RTA Related Sports Related

If yes O Professional O Non-Professional

## Diagnosis

J06.9 - Acute upper respiratory infection, unspecified, R05 - Cough, J30.9 - Allergic rhinitis, unspecified

## Treatment plan, recommended medications, investigations, and/or procedures

**Treatments:** 85025, COMPLETE BLOOD COUNT (CBC) BLOOD,86140, C-REACTIVE PROTEIN (CRP),0188-135906-2441, PULMICORT-(BUDESONIDE: 0.5 MG/ML) SUSPENSION FOR NEBULIZATION,9, GP Consultation,96372, Therapeutic prophylactic or diagnostic injection (specify substance or drug) subcutaneous or intramu,0005-149902-1021, CLOFEN

**Prescription**:0005-107001-0051 - (CAFFEINE : 65 MG) (PARACETAMOL : 500 MG) CAPLETS,4509-559803-1161 - (THYMUS VULGARIS EXTRACT : 5G /100G) SYRUP,2118-290301-0392 - (LEVOCETIRIZINE (DIHCL OR HCL) : 5 MG) FILM COATED TABLETS,

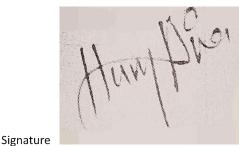
#### **Patient declaration**

I hereby confirm that I am the patient/AXA card holder, Patient's parent or guardian (if under 16 years of age) and I wish to claim and declare that all the details/ information given above are to the best of my knowledge true and correct. I hereby consent to and fully authorize the medical practitioner involved in the patient's care to discuss treatment details and discharge arrangements with and to AXA Insurance (Gulf) B.S.C © representative or any of AXA company affiliates. I subrogate all my rights in relation to this claim and I fully authorize and give access to AXA Insurance (Gulf) B.S.C © representative or any of AXA company affiliates to audit, review and copy all my medical records details including any historical medical records regardless the previous payer/insurer. I agree that

#### 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.

Name



Date:18-Dec-2024

Dr. Humaira Mumtaz
General Practitioner
DHA No: 54155530-002
CITICARE MEDICAL CENTER LLC
DUBAI - U.A.E.

Stamp

Date:18-Dec-2024 WARNING:Any person who knowingly, and with intent to injure, defraud, or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony. Penalties may include but not be restricted to denial of insurance benefits / cover, rendering the insurance contract void and/or legal action to be taken where deemed necessary.

If you have any questions regarding this form or any other aspects of the cover, please contact AXA on UAE +971 (4) 429 4000, Qatar +97 4 412 8733, Bahrain +973 (17) 582 612, KSA +966 (1) 478 0282 quoting the policy and membership numbers. Claims must be submitted along with supporting documents within 30 days from date of service. Send this claim form together with supporting material to Medical Department, AXA Insurance, PO BOX 32505, Dubai, UAE or AXA Insurance, P.O. Box 45, Kingdom of Bahrain or AXA Insurance PO BOX 21044, 11475 Riyadh, Kingdom of Saudi Arabia or AXA Insurance, PO Box 15319, Doha, State of Qatar.