



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.

Prior Approval No

Date Received:

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 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 completed. Thank you in advance for your cooperation which will enable fast and accurate processing.

A. Administrative

Membership No : 13/XC/36001/0/25/E/0	Group Name/ Company Name : CITICARE MEDICAL CENTER LLC
Patient DOB: 12-Jul-1991	Gender : Female
Patient Name : KAREN COLLANTE CASTILLO	
Policy/ Group No.#: Plan : Patient Phone : 0509765667	
Date Of Treatment : 01-Jan-2025 Admission Date: 01-Jan-2025 Discharge Date : 01-Jan-2025	
Email Address : kingkhan@gmail.com	

B. Medical Section

Symptoms Presented

PC: Fever since Saturday
(4 days).

Had previously presented
to Aster clinic but no
relief.

there is cough, pain in
throat and nasal
congestion.

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

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

Medical Condition/ Diagnosis:

Date	Doctor	ICD Code	Diagnosis	
01-Jan-2025	Enomen Goodluck	R05	Cough	
01-Jan-2025	Enomen Goodluck	J30.9	Allergic rhinitis, unspecified	
01-Jan-2025	Enomen Goodluck	J06.9	Acute upper respiratory infection, 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	9	GP Consultation	NA	NA	

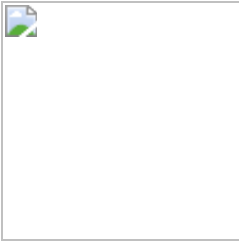
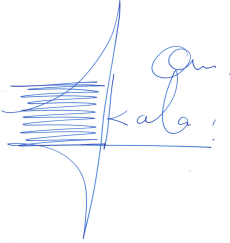
C. Treatments Advised:

Drugs:

Generic/Dose/Form	Instructions	Duration	Quantity
SINECOD / (BUTAMIRATE DIHYDROGEN CITRATE : 0.15% W/V) SYRUP BUTAMIRATE DIHYDROGEN CITRATE [0.15% W/V] / SYRUP (200ML, BOTTLE) / ML	Take 10ML 3 Time(s) per Day For 7 Day(s) after meal	7	1
LORINASE / (LORATADINE : 5 MG (PSEUDOEPHEDRINE SULPHATE : 120 MG TABLETS ORAL / TABLETS (14S, BLISTER PACK / Tablets	Take 1Tablets 2 Time(s) per Day For 7 Day(s) after meal	7	14
GUPISONE 5MG / (PREDNISOLONE : 5 MG TABLETS ORAL / TABLETS (20S, BLISTER PACK / Tablets	Take 2Tablets 1Time(s) perDay 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 ☐ NoIs 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 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. 01-Jan-2025

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 Gate, 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 : to

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