



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:

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 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/36002/0/158/E/0	Group Name/ Company Name : CITICARE MEDICAL CENTER LLC
Patient DOB: 19-Feb-1994	Gender : Male
Patient Name : MOUSTAFA LOTFY ABUTALEB HASSAN	
Policy/ Group No. #: Plan : Patient Phone : 0509765667	
Date Of Treatment : 08-Jan-2025 Admission Date: 08-Jan-2025 Discharge Date : 08-Jan-2025	
Email Address : FENOJE205@GMAIL.COM	

B. Medical Section

Symptoms Presented		
co headache running nose fever on and off dry cough 4th jan. 2025 oe chest is congested no added sounds restless shesha		
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::	
Select Date	Select Date	

Medical Condition/ Diagnosis:				
Date	Doctor	ICD Code	Diagnosis	
08-Jan-2025	Humaira	R06.2	Wheezing	
08-Jan-2025	Humaira	K29.00	Acute gastritis without bleeding	
08-Jan-2025	Humaira	R50.9	Fever, unspecified	
08-Jan-2025	Humaira	R05	Cough	
08-Jan-2025	Humaira	J30.9	Allergic rhinitis, unspecified	
08-Jan-2025	Humaira	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
00:00:00	00:00:00	85025	COMPLETE BLOOD COUNT (CBC) BLOOD	NA	NA

Start Time	End Time	CPT Code	Treatment	Teeth No	Surface
00:00:00	00:00:00	86140	C-REACTIVE PROTEIN (CRP)	NA	NA
05:52:00	06:30:00	0195-107704-0801	CEFTRIAXONE-TABUK IV	NA	NA
05:52:00	06:30:00	96365	Intravenous infusion for therapy prophylaxis or diagnosis (specify substance or drug) initial up to	NA	NA
17:51:15	05:52:00	0005-149902-1021	CLOFEN -(DICLOFENAC SODIUM : 75 MG/3ML) SOLUTION FOR INJECTION	NA	NA
17:51:15	05:52:00	96372	Therapeutic prophylactic or diagnostic injection (specify substance or drug) subcutaneous or intramu	NA	NA
00:00:00	00:00:00	0188-135906-2441	PULMICORT-(BUDESONIDE : 0.5 MG/ML) SUSPENSION FOR NEBULIZATION	NA	NA
00:00:00	00:00:00	9	GP Consultation	NA	NA

C. Treatments Advised:

Drugs:

Generic/Dose/Form	Instructions	Duration	Quantity
AMYDRAMINE - II / (DIPHENHYDRAMINE : 12.5 MG/5ML SYRUP (SUGAR FREE ORAL / SYRUP (SUGAR FREE (120ML, BOTTLE / Syrup	Take 10 ml 3 times in a day	1	1
ARTIZ / (CETIRIZINE HCL : 10 MG) FILM COATED TABLETS CETIRIZINE HCL [10 MG] / FILM COATED TABLETS (10S, BLISTER PACK) / Tablets	Take 1Tablet at night	5	5
ZYNEX 20 / (ESOMEPRAZOLE (AS MAGNESIUM : 20 MG CAPSULES (HARD GELATIN ORAL / CAPSULES (HARD GELATIN (14S, BLISTER / Capsule	Take 1Capsule 2 Time(s) per Day For 7 Day(s) others	7	14
ADOL EXTRA / (CAFFEINE : 65 MG) (PARACETAMOL : 500 MG) CAPLETS CAFFEINE/PARACETAMOL [65 MG 500 MG] / CAPLETS (24S, BOX) / Tablets	Take 1Tablets 2 Time(s) per Day For 6 Day(s) others	6	12
MACROMAX 500 / (AZITHROMYCIN : 500 MG FILM COATED TABLETS ORAL / FILM COATED TABLETS (3S, BLISTER / Tablets	Take 1Tablets 1 Time(s) per Day For 7 Day(s) others	7	7

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
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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 : Humaira

 Signature :	Signature& Stamp:  Dr. Humaira Muntaz General Practitioner DHA No: 54155530-002 CITICARE MEDICAL CENTER LLC DUBAI - U.A.E. 08-Jan-2025
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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

