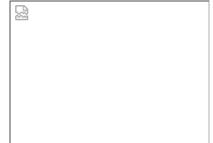
DirectThsclaimformBillingisnotan admissionClaim ofFormliability									
Administrative Section									
Policy number	13/XC/35901/0/145/E/0				Membership number				
Patient name	POOJA GUPTA F	RAJENDRA KUMAR GUPTA		Provider name		CITI	CITICARE MEDICAL CENTER LLC		
Date of treatment	18-Jan-2025	18-Jan-2025		Patient G	Patient Gender		O Male O Female		
Medical Section									
Type of visit  Outpatient Inpatient If Emergency Maternity Dental Optical									
If Pregnant: L.M.P. Date Nature of conception O Natural O Assisted									
Chief complaint									
co body pain throat pain 15 th jan. 2025									
ое									
chest is clear no added sounds									
restless									
History of present illness									
Date	Doctor	Location	Quality	Severity	Duration	Timing	Context	Modifying Factor	Symptoms
No Previous Complaints Found									
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, J00 - Acute nasopharyngitis [common cold]									
Treatment plan, recommended medications, investigations, and/or procedures									
Treatments: 9, GP Consultation									
Prescription:0195-123701-0391 - (CETIRIZINE HCL : 10 MG) FILM COATED TABLETS,									

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## Patient declaration

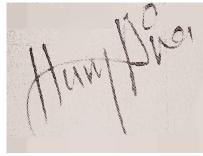
I hereby confirm that I am the patient/AXA card holder, Patient's parent or guardian (if under 16 years of age) and I wish to claim and declare that all the details/ information given above are to the best of my knowledge true and correct. I hereby consent to and fully authorize the medical practitioner 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 a copy of this consent shall have the validity of the original.



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



Signature

Date:18-Jan-2025

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

Signature

Date:18-Jan-2025

Stamp

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

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