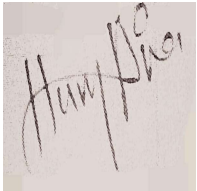


**MEDICAL CLAIM FORM**

Provider Name: CITICARE MEDICAL CENTER LLC	Patient Name: Diala Safwan Saleh	
Insurance Company: AAFIYA MEDICAL BILLING SERVICES LLC	Patient Contact No: 0526887750	File No: 43783
Company Name:	Member ID: I007-026-119188073-01	
Date of Treatment : 12-Jan-2025	Date of Birth: 16-Aug-1997	Gender : Female

Chief Complaints :			
CO SWEATING WEAK LETHARGY 9TH JAN . 2025			
OE chest is clear no added sounds			
restless			
Referral(if needed):			
Clinical Findings		BP: 108	TEMP: 37.3
		HR: 72	RR: 18
Diagnosis: Dehydration	Diagnosis Code:E86.0	Date of Onset 12-Jan-2025	
PEC/CHRONIC ☐ CONGENITAL ☐ MATERNITY ☐ DENTAL ☐ OPTICAL ☐ WORK RELATED ☐ OTHERS ☐			

Treatment Plan: 9, GP Consultation,9, GP Consultation,9, GP Consultation,9, GP Consultation,9, GP Consultation	
Requested Investigations :	Estimated Cost :
Prescription	Estimated Cost :

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  Dr's Name : Humaira  Signature: Stamp: Date: 12-Jan-2025	PATIENT'S DECLARATION: I hereby authorize any Healthcare provider, Insurer, Employer or other organization to release any information regarding my medical condition & history to Aafiya for purpose of determining Insurance benefits.  Patient's Signature(Parent If Minor): Date : 12-Jan-2025
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Aafiya Medical Billing Services reserve its right during the Agreement period with the service provider, survey and audit the service provider's operations with respect to its performance of services, the patient visit details and claims.

24/7 Claims Centre

Helpline: 9714263 0666 | Tel: 971 4 283 8116 | Fax: 971 4 283 8115 | Email: claims@aafiya.ae | Website: www.aafiya.ae