Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	: **charlotte samantha**	**Service Date**	:**20-Jan-2025**	**Network**	: Green
Card No	: **I035-029-120647414-01**	**Health Provider**	:**CITICARE MEDICAL CENTER LLC**	**Direct Access SP - YES**	
Policy Holder	: **charlotte samantha**	**Doctor's Name**	:**Humaira**		
Payer Name	: **SALAMA – Islamic Arab Insurance Company**	**Co-Insurance**	:		

CONSULTATION	LAB/RADIOLOGY	PHYSIO	PHARMACY	IP	MATERNITY	DENTAL
10% max	NIL	NIL	NIL LIMIT	NIL	10%	NA

Remarks :

TPA	: **E CARE - Blue Network**
Validity	: **19-09-2024** To **18-09-2025**
Gender	: **Female**
Date Of Birth	: **30-Jan-2000**
Patient's Tel No	: **0506893097**

☐ **Acute** ☐ **Pre-existing and chronic** ☐ **Maternity**

Chief Complaints : co fever on and off dry cough running nose 15th jan. 2025 Exfoliating lesions on the surface of the 2nd, 3rd and 4th toe of left leg. oe chest is congested no added sounds restless **Duration:**

Vitals: Temp : 36.8 Bp :119 Pulse :102 Resp :18

Clinical Findings:

Diagnosis: J06.9 - Acute upper respiratory infection, unspecified,J30.9 - Allergic rhinitis, unspecified,R05 - Cough,R50.9 - Fever, unspecified,L30.9 - Dermatitis, unspecified,K29.00 - Acute gastritis without bleeding, **Date of Onset** :20/10/2025

Requested Investigations: 85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,86140, C REACTIVE PROTEIN,0188-135906-2441, PULMICORT-(BUDESONIDE : 0.5 MG/ML) SUSPENSION FOR NEBULIZATION,94640, AIRWAY INHALATION TREATMENT,9, Consultation GP **Estimated Cost** :

Prescriptions: 0006-131401-0151 - (BETAMETHASONE : 0.1%) CREAM,0005-116702-2481 - (DIPHENHYDRAMINE : 12.5 MG/5ML SYRUP (SUGAR FREE,6445-533802-1561 - (ESOMEPRAZOLE (AS MAGNESIUM) : 40 MG) DELAYED RELEASE CAPSULES,0005-107001-0051 - (CAFFEINE : 65 MG) (PARACETAMOL : 500 MG) CAPLETS,0139-116206-1171 - (CLAVULANIC ACID : 125 MG) (AMOXICILLIN : 875 MG) TABLETS,0195-123701-0391 - (CETIRIZINE HCL : 10 MG) FILM COATED TABLETS, **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.

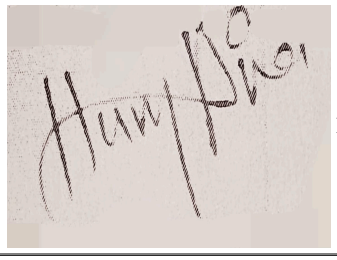
PATIENT'S DECLARATION :

I hereby authorize any Healthcare provider, Insurer, Employer or other organization to release any information regarding my medical condition & history for purpose of determining insurance benefits.

Dr's Name : Humaira **Stamp :**

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

Patient 's signature{Parent if minor} : **Date :** 20-Jan-2025

Signature :  **Date** : 20-Jan-2025