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: *Select Date*

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 comp thank you in advance for your cooperation which will enable fast and accurate processing.

A. Administrative

Membership No : 13/XC/35989/0/63/D/1 Group Name/ Company Name : CITICARE MEDICAL CENTER LLC

Patient DOB: 16-May-2022 Gender : Female Patient Name : CEYLIN GUMUS

Policy/ Group No.#: Plan : Patient Phone : 0509765667

Date Of Treatment : 21-Jan-2025 Admission Date: 21-Jan-2025 Discharge Date : 21-Jan-2025

Email Address :

B. Medical Section

Symptoms Presented

pc : cough , fever , runny node

chest congested

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

Date on which the patient first presented to any this condition:: *Select Date*

Medical Condition/ Diagnosis:

Date	Doctor	ICD Code	Diagnosis	N
21-Jan-2025	SANDIA	J06.9	Acute upper respiratory infection, unspecified	
21-Jan-2025	SANDIA	R05	Cough	
21-Jan-2025	SANDIA	R50.9	Fever, unspecified	

Investigations((Describe necessary investigations requested to define the diagnosis):

Start Time	End Time	CPT Code	Treatment	Teeth No	Surface	N
00:00:00	00:00:00	8787	VOLTAREN SUPPOSITORY			
00:00:00	00:00:00	0195-107704-0802	CEFTRIAXONE-TABUK IM			d g n
00:00:00	00:00:00	96372	INJECTION SERVICE-IM			
00:00:00	00:00:00	94640	Pressurized or nonpressurized inhalation treatment for acute airway obstruction or for sputum induction for diagnostic purposes			

Start Time	End Time	CPT Code	Treatment	Teeth No	Surface	N
			(eg, with an aerosol generator, nebulizer, metered dose inhaler or intermittent positive pressure breathing [IPPB] device)			
00:00:00	00:00:00	0188-135906-2441	PULMICORT-(BUDESONIDE : 0.5 MG/ML) SUSPENSION FOR NEBULIZATION			
09:57:49	10:30:49	0195-107704-0802	CEFTRIAXONE-TABUK IM-(CEFTRIAXONE : 1 G) POWDER FOR INJECTION	NA	NA	d g m
00:00:00	00:00:00	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	
09:57:49	10:30:49	96365	Intravenous infusion for therapy prophylaxis or diagnosis (specify substance or drug) initial up to	NA	NA	

C. Treatments Advised:

Drugs:

Generic/Dose/Form	Instructions	Duration	Quanti
ADOL 120MG/5ML / (PARACETAMOL : 120 MG/5ML) SUSPENSION PARACETAMOL [120 MG/5ML] / SUSPENSION (100ML, BOTTLE) / Syrup	Take 1Syrup 3Time(s) perDay For 3 Day(s) others	3	1
ZYRTEC / (CETIRIZINE HCL : 1 MG/ML) SOLUTION (ORAL) CETIRIZINE HCL [1 MG/ML] / SOLUTION (ORAL) (75ML, BOTTLE) / Syrup	Take 1Syrup 1Time(s) perDay For 3 Day(s) evening	3	1
CEFIX / (CEFIXIME : 100 MG/5ML POWDER FOR SUSPENSION ORAL / POWDER FOR SUSPENSION (60ML , GLASS BOTTLE + GRADUATED SPOON / Syrup	Take 1Syrup 2Time(s) perDay For 5 Day(s) after meal	5	1

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

Patient Declaration	Medical practitioner declaratio
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 partic given are to the best of my kno true and correct. **Name :** SANDIA

Signature :

Signature& Stamp:

21-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 treat 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 Ga 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 : *Select Date* to *Select Date*

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