

**MEDICAL CLAIM FORM**

Provider Name: CITICARE MEDICAL CENTER LLC	Patient Name: SUMERA KHAN	
Insurance Company: AAFIYA MEDICAL BILLING SERVICES LLC	Patient Contact No: 0585216824	File No: 45484
Company Name:	Member ID: I022-026-121764865-01	
Date of Treatment : 21-Jan-2025	Date of Birth: 20-Apr-1990	Gender : Female

Chief Complaints :			
pc : cough , trouble breathing .chest tightness on and off from january, fever , for 1 week			
known asthmatic on inhaler for few years			
o/e : wheezing all over chest			
Referral(if needed):			
Clinical Findings		BP: 113	TEMP: 37
		HR: 86	RR: 18
Diagnosis: Cough variant asthma, Airway disease due to other specific organic dusts, Mild intermittent asthma with (acute) exacerbation		Diagnosis Code:J45.991, J66.8, J45.21	Date of Onset 21-Jan-2025
PEC/CHRONIC ☐ CONGENITAL ☐ MATERNITY ☐ DENTAL ☐ OPTICAL ☐ WORK RELATED ☐ OTHERS ☐			

Treatment Plan: 94640, Pressurized or nonpressurized inhalation treatment for acute airway obstruction or for sputum induction for diagnostic purposes (eg, with an aerosol generator, nebulizer, metered dose inhaler or intermittent positive pressure breathing [IPPB] device),0188-135906-2441, PULMICORT-(BUDESONIDE : 0.5 MG/ML) SUSPENSION FOR NEBULIZATION,96360, Intravenous infusion, hydration; initial, 31 minutes to 1 hour,9, GP Consultation,85027, Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count),86005, Allergen specific IgE; qualitative, multiallergen screen (dipstick, paddle, or disk)

Requested Investigations :			Estimated Cost :
Prescription			Estimated Cost :
Medicine	Dose	Duration	
(BUDESONIDE : 0.5 MG/ML) SUSPENSION FOR NEBULIZATION	SUSPENSION FOR NEBULIZATION (2ML X 20, UNIT)	1	
(MONTELUKAST (AS SODIUM : 10 MG TABLETS	TABLETS (30S, BLISTER	15	
(BUDESONIDE : 160 MCG) (FORMOTEROL FUMARATE : 4.5 MCG) POWDER FOR INHALATION	POWDER FOR INHALATION (120 DOSE, METERED DOSE INHALER)	15	
(BROMHEXINE HYDROCHLORIDE : 4 MG/5ML) SYRUP	SYRUP (100ML, BOTTLE)	7	

MEDICAL PRACTIONER 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 : SANDIA



Signature:

Stamp:



Date: 21-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 benifits.



Patient's Signature(Parent If Minor):

21-Jan-2025

Date :

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