DirectThsclaimformBillingisnotan admissionClaim ofFormliability

Administrative Section

Policy number	13/XC/35989/0/69/E/0	Membership number	
Patient name	HARI K C	Provider name	CITICARE MEDICAL CENTER LLC
Date of treatment	25-Jan-2025	Patient Gender	◉ Male ○ Female

Medical Section

Type of visit ☐ **Outpatient** ☐ **Inpatient If** ☐ **Emergency** ☐ **Maternity** ☐ **Dental** ☐ **Optical**

If Pregnant: L.M.P. Date Nature of conception ○ **Natural** ○ **Assisted**

Chief complaint

pc :sorethroat , cough is dry, fever for 4 days

epigastric pain for 1 month usually at bed time

treated for h pylori

o/e hyperemia of pharynx

abdomen : gaseous distension

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 ○ **Professional** ○ **Non-Professional**

Diagnosis

J02.9 - Acute pharyngitis, unspecified, K29.00 - Acute gastritis without bleeding

Treatment plan, recommended medications, investigations, and/or procedures

Treatments: 85025, COMPLETE BLOOD COUNT (CBC) BLOOD,0188-135906-2441, PULMICORT-(BUDESONIDE : 0.5 MG/ML) SUSPENSION FOR NEBULIZATION,0005-174202-0781, RISEK 40MG-(OMEPRAZOLE : 40 MG) POWDER FOR INFUSION,9, GP Consultation

Prescription:1217-373201-2401 - (TOLPERISONE : 150 MG) SUGAR COATED TABLETS,2150-575201-1171 - (CALCIUM : 400 MG (VITAMIN D3 : 200 IU (MAGNESIUM : 100 MG (ZINC : 4 MG TABLETS,0006-104201-1161 - (TRIPROLIDINE : 0.25 MG/ML) (GUAIFENESIN : 20 MG/ML) (PSEUDOEPHEDRINE : 6 MG/ML) SYRUP,0195-123701-0391 - (CETIRIZINE HCL : 10 MG FILM COATED TABLETS,

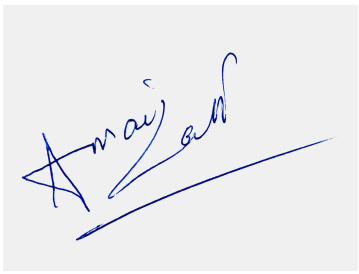
Patient declaration

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

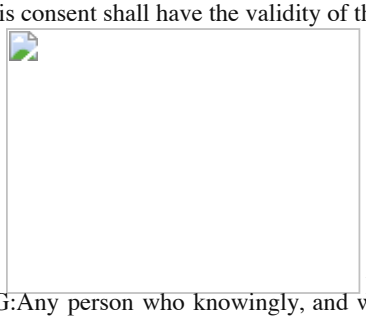
Medical practitioner declaration

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:25-Jan-2025

copy of this consent shall have the validity of the original.



Dr. Amaizah Ishtiaq
General Practitioner
DHA: 98486553-001
CITICARE MEDICAL CENTER
DUBAI - U.A.E

Stamp

Signature Date:25-Jan-2025

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 Qatar.