Administrative MEDICAL CLAIM FORM Claim Ref

Patient Name	: **Muhammed Basil Kothayam Veedu**	**Service Date**	:**20-Mar-2025** **Network** : Green
Card No	: **I035-029-121827175-01**	**Health Provider**	:**CITICARE MEDICAL CENTER LLC** **Direct Access SP**
Policy Holder	: **Muhammed Basil Kothayam Veedu**	**Doctor's Name**	:**Humaira**
Payer Name	: **SALAMA – Islamic Arab Insurance Company**	**Co-Insurance**	:
TPA	: **E CARE - Blue Network**	**Remarks**	:
Validity	: **16-12-2024** To **15-12-2025**		
Gender	: **Male**		
Date Of Birth	: **19-Mar-1988**		
Patient's Tel No	: **0559381662**		

CONSULTATION	LAB/RADIOLOGY	PHYSIO	PHARMACY	IP	MATEF
10% max	NIL	NIL	NIL LIMIT	NIL	10%

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

Chief Complaints : during playing so other player hitted in the chest. now complain of pain in ribs on examination there is no abrasion over ribs. **Duration:**

Vitals: Temp : 37.4 Bp :115 Pulse :119 Resp :0

Clinical Findings:

Diagnosis: R07.81 - Pleurodynia,R52 - Pain, unspecified, **Date of Onset** : 20/2

Requested Investigations: 0005-149902-1021, CLOFEN ,96372, THER/PROPH/DIAG INJ SC/IM,9, Consultation GP **Estimated Cost** :

Prescriptions: 0031-149904-1171 - (DICLOFENAC SODIUM : 50 MG) TABLETS,0005-107902-1172 - (IBUPROFEN : 400 MG 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 Healthca Employer or other organization regarding my medical condition determining insurance benefits.

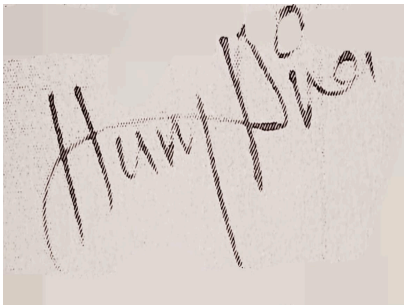
Dr's Name : Humaira

Stamp :

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

Patient 's signature{Parent if minor} :

Signature :



Date : 20-Mar-2025