

Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name : DAVID JAMES

Card No : I035-029-122127153-01

Policy Holder : DAVID JAMES

Payer Name : SALAMA – Islamic Arab Insurance Company

TPA : E CARE - Blue Network

Validity : 03-08-2024 To 02-08-2025

Gender : Male

Date Of Birth : 27-May-1993

Patient's Tel No : 447508039690

Service Date:28-Mar-2025

Health Provider :CITICARE MEDICAL CENTER LLC

Doctor's Name :DR Amaizah

Co-Insurance :

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

Remarks :

Network : Green

Direct Access SP - YES

☐ Acute

☐ Pre-existing and chronic

☐ Maternity

Chief Complaints : follow up acute bacterial infection is diagnosed on cbc and crp needs antibiotic appetitie reduced oral intake is reduced pc: sore throat , cough with sputum , bodypain , low grade fever started 20/03/25 o/e : look lethargic and dehydrated pharynx hyperemia chest congested

Duration:

Vitals:Temp : 37.1 Bp :120 Pulse :96 Resp :18

Clinical Findings:

Diagnosis: J02.9 - Acute pharyngitis, unspecified,R50.9 - Fever, unspecified,R05 - Cough,R06.2 - Wheezing,

Date of Onset :28/42/2025

Requested Investigations: 0195-107704-0801, CEFTRIAXONE-TABUK IV,2190-106618-1001, PARAFUSIV,94640, AIRWAY INHALATION TREATMENT,0188-135906-2441, PULMICORT,0102-152902-1001, LACTATED RINGERS INJECTION USP,0005-111805-1021, CHLOROHISTOL 10MG-(CHLORPHENIRAMINE MALEATE : 10 MG/ML) SOLUTION FOR INJECTION,9.01, Follow Up Consultation GP,96372, THER/PROPH/DIAG INJ SC/IM,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE,96360, HYDRATION IV INFUSION INIT,0005-149902-1021, CLOFEN ,96365, THER/PROPH/DIAG IV INF INIT,96374, THER/PROPH/DIAG INJ IV PUSH

Estimated : Cost

Prescriptions: 0097-127405-0391 - (AZITHROMYCIN : 500 MG) FILM COATED TABLETS,0188-135906-2441 - (BUDESONIDE : 0.5 MG/ML) SUSPENSION FOR NEBULIZATION,

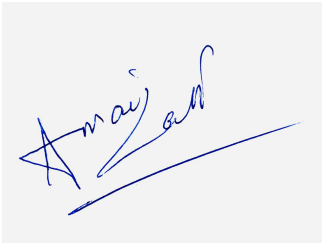
Estimated : Cost

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.

Dr's Name : DR Amaizah

Stamp :

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

Signature :

Date : 28-Mar-2025

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.

Patient 's signature{Parent : if minor}



Date : Mar-2025