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:18-Apr-2025 **Network** : Green

Health Provider **:CITICARE MEDICAL CENTER LLC** **Direct Access SP - YES**

Doctor's Name **:AISHA**

Co-Insurance :

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

Remarks :

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

Chief Complaints : PATIENT CAME WITH DRY COUGH FOR TWO WEEKS ITS DRY COUGH PATIENT **Duration:**
HAVING FEELING OF CHEST COMPRESSION AND CHOKIB OE CHEST IS CONGESTED WHEEZING
MAINLY RIGHT SIDE ON THE BASIS OF ACUTE SYMPTOMS LIKE SHORTNESS OF BREAT CHEST
COMPRESSION ,HE HAS ACUTE ASTHMA HE HAS ALSO PAST HISTORY OF SAME ISSUE

Vitals:

Clinical Findings:

Diagnosis: **Date of Onset** : 18/40/2025

Requested Investigations: 0188-135906-2441, PULMICORT-(BUDESONIDE : 0.5 MG/ML) SUSPENSION FOR NEBULIZATION,94640, AIRWAY INHALATION TREATMENT,9.01, Follow Up Consultation GP,96365, THER/PROPH/DIAG IV INF INIT,0195-107704-0801, CEFTRIAXONE-TABUK IV **Estimated Cost** : **Prescriptions:**

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 Healthcare provider, Insurer, Employer or other organization to release any information regarding my medical condition & history for purpose of determining insurance benefits.

Dr's Name : AISHA

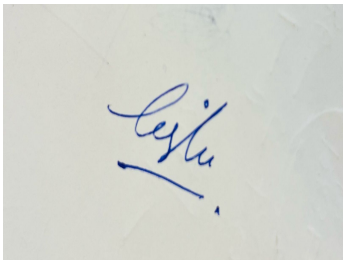
Stamp :

Dr. Aisha Umer
Physician- General Practitioner
DHA- 40131439-002
CITICARE MEDICAL CENTER
DUBAI - U.A.E

Patient 's signature{Parent if minor} :

Date : 18-Apr-2025

Signature :



Date : 18-Apr-2025