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:25-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 : pt came for follow up . he still have cough .but much improved chest is mild congested he has severe pain in the intercostal space due to cough **Duration:**

Vitals: Temp : 36.4 Bp :103 Pulse :97 Resp :18

Clinical Findings:

Diagnosis: J45.991 - Cough variant asthma,R06.2 - Wheezing,J22 - Unspecified acute lower respiratory infection,R07.82 - Intercostal pain,R52 - Pain, unspecified, **Date of Onset** :25/37/2025

Requested Investigations: 0188-135906-2441, PULMICORT-(BUDESONIDE : 0.5 MG/ML) SUSPENSION FOR NEBULIZATION,94640, AIRWAY INHALATION TREATMENT,9, Consultation GP **Estimated Cost** :

Prescriptions: 0009-122302-0391 - (ETORICOXIB : 120 MG) FILM COATED TABLETS,0005-116702-2481 - (DIPHENHYDRAMINE : 12.5 MG/5ML) SYRUP (SUGAR FREE),0207-142901-1452 - (CEFIXIME : 200 MG) CAPSULES (HARD GELATIN),0005-119803-1171 - (PREDNISOLONE : 20 MG) TABLETS,0188-272103-0791 - (BUDESONIDE : 160 MCG) (FORMOTEROL FUMARATE : 4.5 MCG) POWDER FOR INHALATION, **Estimated Cost** :

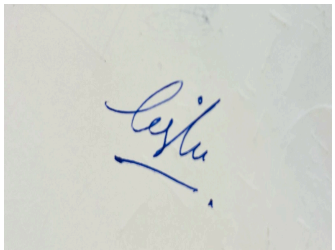
MEDICAL PRACTITIONER DECLARATION :

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 : AISHA

Stamp :

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

Signature : 

Date : 25-Apr-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 : 25-Apr-2025