

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:27-Apr-2025

Health Provider :CITICARE MEDICAL CENTER LLC

Doctor's Name :Dr.Farhan Iyas

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

Vitals:Temp : 36.8 Bp :120 Pulse :78 Resp :18

Clinical Findings:

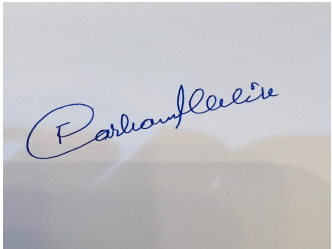
Diagnosis: J45.991 - Cough variant asthma,R06.2 - Wheezing,J22 - Unspecified acute lower respiratory infection,R52 - Pain, unspecified,Date of Onset :27/04/2025

Requested Investigations: 0188-135906-2441, PULMICORT,94640, AIRWAY INHALATION TREATMENTEstimated 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.

Dr's Name : Dr.Farhan Iyas

Signature :

Stamp :

Dr .Frahan Ilyas Malik
Physician-General Practitioner
DHA-06441782-001
CITICARE MEDICAL CENTER
DUBAI U.A.E

Date : 27-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 : Apr-2025