

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-Apr-2025

Network

: Green

Health Provider : CITICARE MEDICAL CENTER LLC

Direct Access SP - YES

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 :

☐ Acute
 ☐ Pre-existing and chronic
 ☐ Maternity

Chief Complaints : FOLOW UP FOR NEBULIZATION TREATMENT FOR CHRONIV PERSISTENT COUGH HIGH EOSINOPHILS ON CBC

Duration:

Vitals: Temp : 36.8 Bp :102 Pulse :78 Resp :18

Clinical Findings:

Diagnosis: R09.81 - Nasal congestion, R05 - Cough, R06.2 - Wheezing,

Date of Onset : 28/17/2025

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

Estimated :
 Cost

Prescriptions: 0188-135907-2441 - (BUDESONIDE : 0.25 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.

PATIENT'S DECLARATION :

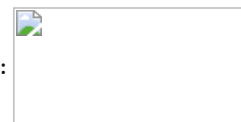
I hereby authorize any Healthcare provider, Insurer, Employer or other organization to release any information regarding my medical condition & history for purpose of determining insurance benefits.

Dr's Name : DR Amaizah

Stamp :

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

Patient 's
 signature {Parent :
 if minor}



28-
 Date : Apr-
 2025

Signature :

Date : 28-Apr-2025