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} : **Date :** 28-Apr-2025

Signature : **Date** : 28-Apr-2025