

Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	: DAVID JAMES	Service Date	:29-Apr-2025	Network	: Green														
Card No	: I035-029-122127153-01	Health Provider	:CITICARE MEDICAL CENTER LLC	Direct Access SP - YES															
Policy Holder	: DAVID JAMES	Doctor's Name	:DR Amaizah																
Payer Name	: SALAMA – Islamic Arab Insurance Company	Co-Insurance	<table><tr><td>CONSULTATION</td><td>LAB/RADIOLOGY</td><td>PHYSIO</td><td>PHARMACY</td><td>IP</td><td>MATERNITY</td><td>DENTAL</td></tr><tr><td>10% max</td><td>NIL</td><td>NIL</td><td>NIL LIMIT</td><td>NIL</td><td>10%</td><td>NA</td></tr></table>			CONSULTATION	LAB/RADIOLOGY	PHYSIO	PHARMACY	IP	MATERNITY	DENTAL	10% max	NIL	NIL	NIL LIMIT	NIL	10%	NA
CONSULTATION	LAB/RADIOLOGY	PHYSIO	PHARMACY	IP	MATERNITY	DENTAL													
10% max	NIL	NIL	NIL LIMIT	NIL	10%	NA													
TPA	: E CARE - Blue Network	Remarks	:																
Validity	: 03-08-2024 To 02-08-2025																		
Gender	: Male																		
Date Of Birth	: 27-May-1993																		
Patient's Tel No	: 447508039690																		

☐ Acute

☐ Pre-existing and chronic

☐ Maternity

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

Duration:

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

Clinical Findings:

Diagnosis:

Date of Onset

: 29/53/2025

Requested Investigations: 94640, AIRWAY INHALATION TREATMENT

Estimated Cost

:

Prescriptions:

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.

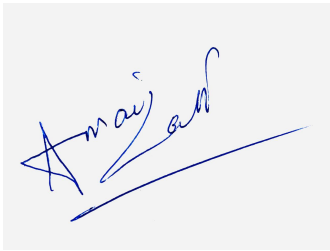
Dr's Name

: DR Amaizah

Stamp :

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

Signature :



Date

: 29-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}



29-
Date : Apr-
2025