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:30-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 : OLOW UP FOR NEBULIZATION TREATMENT FOR CHRONIV PERSISTENT COUGH HIGH EOSINOPHILS ON CBC **Duration:**

Vitals:

Clinical Findings:

Diagnosis: R06.2 - Wheezing,J45.991 - Cough variant asthma, **Date of Onset** : 30/32/2025

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

Estimated Cost :

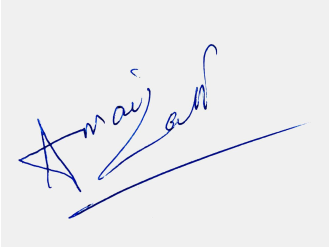
Prescriptions: 0118-114501-1161 - (AMBROXOL : 15 MG/5ML) SYRUP,

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** : 30-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 :** 30-Apr-2025