

Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	: DAVID JAMES	Service Date	: 01-May-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 : FOLOW UP FOR NEBULIZATION TREATMENT FOR CHRONIV PERSISTENT COUGH HIGH EOSINOPHILS ON CBC

Duration:

Vitals:

Clinical Findings:

Diagnosis: J45.991 - Cough variant asthma,R06.2 - Wheezing,

Date of Onset : 01/01/2025

Requested Investigations: 94640, AIRWAY INHALATION TREATMENT,0188-135906-2441, PULMICORT,0005-111805-1021, CHLOROHISTOL 10MG,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE,96372, THER/PROPH/DIAG INJ SC/IM

Estimated : Cost

Prescriptions: 0138-163701-1161 - (AMMONIUM CHLORIDE : 5 MG/ML (CHLORPHENIRAMINE : 0.2 MG/ML (DEXTROMETHORPHAN : 2 MG/ML (GUAIFENESIN : 20 MG/ML SYRUP,

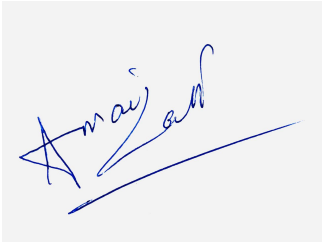
Estimated : Cost

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 : 01-May-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 : May-2025