Administrative

MEDICAL CLAIM FORM

Claim Ref:

Service Date:10-May-2025 Network **Patient** : DAVID JAMES

Co-

Health Name :CITICARE MEDICAL CENTER LLC **Direct Access SP - YES** Provider

Card No : 1035-029-122127153-01

Policy : DAVID JAMES Holder

: SALAMA – Islamic Arab Payer Insurance Company Name

: E CARE - Blue Network TPA

Validity : 03-08-2024 To 02-08-2025

Gender : Male

Date Of Birth

: 27-May-1993

: Green

Doctor's :DR Amaizah Name

Insurance

CONSULTATION	LAB/RADIOLOGY	PHYSIO	PHARMACY	IP	MATERNITY	DENTAL
10% max	NIL	NIL	NIL LIMIT	NIL	10%	NA

Remarks

Patient's Tel No : 447508039690					
☐ Acute ☐ Pre-existing and chi	ronic	☐ Maternity			
Chief Complaints: pc: nasal congestion and brea last 1 month left sided chest pain, more on exerti heart disease hx of hypothyroidism in mother hypirritable due too pain chest wheezing	ion family hx of cardiac disease ,, ischemic				
Vitals:Temp: 36.8 Bp:130 Pulse:88 Resp:18					
Clinical Findings: Diagnosis: R07.9 - Chest pain, unspecified,R06.2 - of htn,E03.9 - Hypothyroidism, unspecified,	- Wheezing,R03.0 - Elevated blood-pressure	reading, w/o diagnosis Date of :10/42/2025 Onset			
Requested Investigations: 93000, ELECTROCARDIOGRAM COMPLETE,94640, AIRWAY INHALATION TREATMENT,0188-135906-2441, PULMICORT,9, Consultation GP Estimated: Cost					
Estimated Cos Prescriptions:	st :				
MEDICAL PRACTITIONER DECLARATION: I declare that I am the patient's medical practitio 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 : DR Amaizah S Name	Dr. Amaizah Ishtiaq General Practitioner DHA: 98486553-001 CITICARE MEDICAL CENTER DUBAI - U.A.E	Patient 's signature{Parent : if minor} 10- Date : May- 2025			
Signature:	Date : 10-May-2025				