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:10-May-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 : pc : nasal congestion and breathing problem sec to long standing cough for last 1 month left sided chest pain , more on exertion family hx of cardiac disease ,, ischemic heart disease hx of hypothyroidism in mother hyperlipidemia on lab reports t3 low o/e : look irritable due too pain chest wheezing **Duration:**

Vitals: Temp : 36.8 Bp :130 Pulse :88 Resp :18

Clinical Findings:

Diagnosis: R07.9 - Chest pain, unspecified,R06.2 - Wheezing,R03.0 - Elevated blood-pressure reading, w/o diagnosis of htn,E03.9 - Hypothyroidism, unspecified,E78.2 - Mixed hyperlipidemia, **Date of Onset** :10/45/2025

Requested Investigations: 93000, ELECTROCARDIOGRAM COMPLETE,94640, AIRWAY INHALATION TREATMENT,0188-135906-2441, PULMICORT,9, Consultation GP,0005-149902-1021, CLOFEN ,96372, THER/PROPH/DIAG INJ SC/IM,2190-106618-1001, PARAFUSIV,96365, THER/PROPH/DIAG IV INF INIT **Estimated Cost** :

Prescriptions: 0188-155601-0391 - (ROSUVASTATIN (AS CALCIUM) : 20 MG) FILM COATED TABLETS,0201-124202-0341 - (ASPIRIN : 75 MG) ENTERIC COATED TABLETS, **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** : 10-May-2025

Signature : **Date** : 10-May-2025