

Administrative

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:15-May-2025

Health Provider :CITICARE MEDICAL CENTER LLC

Doctor's Name :Dr.Farhan Ilyas

Co-Insurance :

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

Remarks :

Network : Green

Direct Access SP - YES

☐ Acute

☐ Pre-existing and chronic

☐ Maternity

Chief Complaints : pain in left sides of ribs since more than one month cough which is dry in nature

Duration:

Vitals:Temp : 36.8 Bp :105 Pulse :85 Resp :18

Clinical Findings:

Diagnosis: M62.838 - Other muscle spasm,R05 - Cough,R07.9 - Chest pain, unspecified,

Date of Onset :15/43/2025

Requested Investigations: 0005-149902-1021, CLOFEN ,96372, THER/PROPH/DIAG INJ SC/IM,9, Consultation GP,9, Consultation GP

Estimated Cost :

Prescriptions: 0097-142201-0391 - (DICLOFENAC POTASSIUM : 50 MG) FILM COATED TABLETS,3819-373201-0391 - (TOLPERISONE HCL : 150 MG) FILM 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.

Dr's Name : Dr.Farhan Ilyas

Stamp :

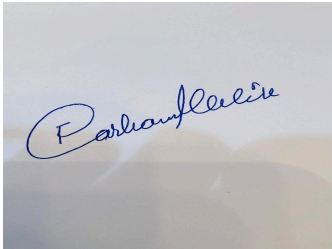
Dr .Frahan Ilyas Malik

Physician-General Practitioner

DHA-06441782-001

CITICARE MEDICAL CENTER

DUBAI U.A.E

Signature :

Date : 15-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

https://irhamc.visionsoftwares.ae/mr_ecare_claim_print.aspx?appId=62672&patId=57323

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