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:17-May-2025 **Network** : Green

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

Doctor's Name **:Dr.Farhan Iyas**

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 : muscle pain and spasm on left side of ribs **Duration :**

Vitals: Temp : 36.8 Bp :120 Pulse :85 Resp :18

Clinical Findings:

Diagnosis: M62.838 - Other muscle spasm,R52 - Pain, unspecified, **Date of Onset** : 17/09/2025

Requested Investigations: 0005-149902-1021, CLOFEN ,96372, THER/PROPH/DIAG INJ SC/IM,9.01, Follow Up Consultation GP,9.01, Follow Up Consultation GP **Estimated Cost** :

Prescriptions: **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.

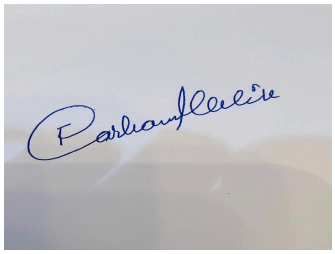
PATIENT'S DECLARATION :

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.Farhan Iyas **Stamp :**

Dr .Frahan Ilyas Malik
Physician-General Practitioner
DHA-06441782-001
CITICARE MEDICAL CENTER
DUBAI U.A.E

Patient 's signature{Parent if minor} : **Date** : 17-May-2025

Signature :  **Date** : 17-May-2025