Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	**: NIMISH SAMUEL MATHEW**	**Service Date**	**:07-Jun-2025** **Network** : Green
Card No	**: I035-029-121322126-01**	**Health Provider**	**:CITICARE MEDICAL CENTER LLC** **Direct Access SP - YES**
Policy Holder	**: NIMISH SAMUEL MATHEW**	**Doctor's Name**	**:Dr.Farhan Iyas**
Payer Name	**: SALAMA – Islamic Arab Insurance Company**	**Co-Insurance**	:
TPA	**: E CARE - Blue Network**	**Remarks**	:
Validity	**: 14-09-2024** To **13-09-2025**		
Gender	**: Male**		
Date Of Birth	**: 16-Jul-1994**		
Patient's Tel No	**: 0562818528**		

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

☐ **Acute** ☐ **Pre-existing and chronic** ☐ **Maternity**

Chief Complaints : cough productive chest congestion previous history of asthma nasal congestion o/e: chest wheezing he is a chronic smoker **Duration:**

Vitals: Temp : 36.8 Bp :120 Pulse :82 Resp :18

Clinical Findings:

Diagnosis: J06.9 - Acute upper respiratory infection, unspecified,R05 - Cough,J20.9 - Acute bronchitis, unspecified,J45.909 - Unspecified asthma, uncomplicated,R09.81 - Nasal congestion,J45.991 - Cough variant asthma, **Date of Onset** :07/21/2025

Estimated Cost :

Requested Investigations: 9, Consultation GP

Prescriptions: 0189-126001-1971 - (FLUTICASONE : 27.5MCG/DOSE) LIQUID FOR SPRAY (NASAL),8033-412008-0791 - (FLUTICASONE PROPIONATE : 250 MCG) (SALMETEROL (AS XINAFOATE) : 50 MCG) POWDER FOR INHALATION,2027-560101-0391 - (IBUPROFEN : 150 MG) (PARACETAMOL : 500 MG) FILM COATED TABLETS,0205-123701-0392 - (CETIRIZINE HCL : 10 MG) FILM COATED TABLETS,0027-265802-1161 - (BUTAMIRATE DIHYDROGEN CITRATE : 0.15% W/V) SYRUP,0195-395404-0391 - (MONTELUKAST (AS SODIUM) : 10 MG) FILM COATED TABLETS,0188-135906-2441 - (BUDESONIDE : 0.5 MG/ML) SUSPENSION FOR NEBULIZATION,0397-116207-0391 - (AMOXICILLIN : 500 MG) (CLAVULANIC ACID : 125 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.

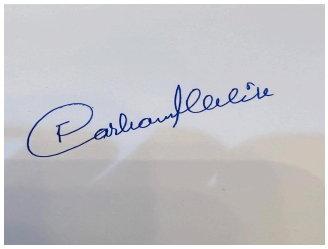
PATIENT'S DECLARATION :

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 :** 07-Jun-2025

Signature :  **Date** : 07-Jun-2025