Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	: **CHAMARA SAMPATH BANDARA BAMUNU**	**Service Date**	**:16-Jun-2025**
Card No	: **I035-029-119235290-01**	**Health Provider**	**:CITICARE MEDICAL CENTER LLC**
Policy Holder	: **CHAMARA SAMPATH BANDARA BAMUNU**	**Doctor's Name**	**:AISHA**
Payer Name	: **SALAMA – Islamic Arab Insurance Company**	**Co-Insurance**	:
TPA	: **E CARE - Blue Network**	**Remarks**	:
Validity	: **28-05-2025** To **27-05-2026**		
Gender	: **Male**		
Date Of Birth	: **19-Jun-1992**		
Patient's Tel No	: **0561450977**		

Network : Green

Direct Access SP - YES

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 : pc: nausea and numbness of of hands after eating food . hopc : pt came with **Duration:** nausea and heartburn after eating food 20 mints ago . he also complain of numbness of hand .he also complain of shoulder pain that is continous for the last one week . o/e .no epigastric tenderness power of hand is 5/5 allergies. None . pmh: history of hypercholesterolemia gastritis

Vitals: Temp : 36.8 Bp :120 Pulse :78 Resp :18

Clinical Findings:

Diagnosis: K29.00 - Acute gastritis without bleeding,R12 - Heartburn,R11.0 - Nausea,E86.0 - Dehydration,R07.9 - Chest pain, unspecified,M62.838 - Other muscle spasm,

Date of Onset :16/08/2025

Requested Investigations: 93000, ELECTROCARDIOGRAM COMPLETE,0005-174202-0781, RISEK 40MG-(OMEPRAZOLE : 40 MG) POWDER FOR INFUSION,0005-150403-1021, PREMOSAN - (METOCLOPRAMIDE : 10 MG/2ML) SOLUTION FOR INJECTION,96372, THER/PROPH/DIAG INJ SC/IM,96360, HYDRATION IV INFUSION INIT,0439-152905-1001, LACTATED RINGERS INJECTION USP,9, Consultation GP,96365, THER/PROPH/DIAG IV INF INIT

Estimated Cost :

Prescriptions: 0252-150407-1171 - (METOCLOPRAMIDE : 10 MG) TABLETS,0207-533801-1451 - (ESOMEPRAZOLE (AS MAGNESIUM) : 20 MG) CAPSULES (HARD GELATIN),

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 : AISHA

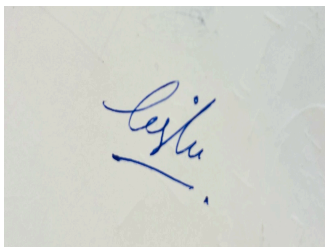
Stamp :

Dr. Aisha Umer
Physician- General Practitioner
DHA- 40131439-002
CITICARE MEDICAL CENTER
DUBAI - U.A.E

Patient 's signature{Parent if minor} :

Date : 16-Jun-2025

Signature :



Date : 16-Jun-2025