Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	: **CHAMARA SAMPATH BANDARA BAMUNU**	**Service Date**	**:21-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	: **0561250977**		

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 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 follow up total cholesterol is high vitamin d deficiency high alp , ggt high **Duration:**

Vitals:

Clinical Findings:

Diagnosis: E78.00 - Pure hypercholesterolemia, unspecified,E55.9 - Vitamin D deficiency, unspecified,K76.0 - Fatty (change of) liver, not elsewhere classified,K81.9 - Cholecystitis, unspecified, **Date of Onset** :21/46/2025

Requested Investigations: 76705, ULTRASOUND ABDOMINAL REAL TIME W/IMAGE LIMITED,9.01, Follow Up Consultation GP **Estimated Cost** :

Prescriptions: **Estimated Cost** :

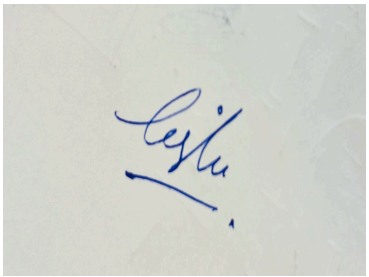
MEDICAL PRACTITIONER DECLARATION :

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.

Dr's Name : AISHA

Stamp :

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

Signature : 

Date : 21-Jun-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 : 21-Jun-2025