

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

:20-Jun-2025

Health Provider

:CITICARE MEDICAL CENTER LLC

Doctor's Name

:DR Amaizah

Co-Insurance

:

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

Network

: Green

Direct Access SP

- YES

Remarks

:

☐ Acute

☐ Pre-existing and chronic

☐ Maternity

Chief Complaints

: pc : sevre bouts of cough ehile exertion with sputum greenish in color started 16/06/26 o/e : chest : wheezing high eosinophils on cbc

Duration:

Vitals

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

Clinical Findings:

Diagnosis

: J45.991 - Cough variant asthma,R06.2 - Wheezing,

Date of Onset

: 20/58/2025

Requested Investigations

: 94640, AIRWAY INHALATION TREATMENT,0188-135906-2441, PULMICORT,9, Consultation GP

Estimated Cost

:

Prescriptions

: 0005-116801-1161 - (SODIUM CITRATE : 57 MG/5ML) (AMMONIUM CHLORIDE : 131.5 MG/5 ML) (MENTHOL : 1.1 MG/5 ML) (DIPHENHYDRAMINE : 13.5 MG/5ML) SYRUP,

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.

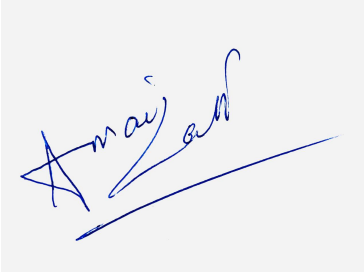
Dr's Name

: DR Amaizah

Stamp :

Dr. Amaizah Ishtiaq
General Practitioner
DHA: 98486553-001
CITICARE MEDICAL CENTER
DUBAI - U.A.E

Signature :



Date

: 20-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

: Jun-2025