Administrative MEDICAL CLAIM FORM Claim Ref

Patient Name	**: ABDUL ARIF BABU BABU**	**Service Date**	**:11-Jul-2025**
Card No	**: I035-029-118648063-01**	**Health Provider**	**:CITICARE MEDICAL CENTER LLC**
Policy Holder	**: ABDUL ARIF BABU BABU**	**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	**: 12-Jun-1976**		
Patient's Tel No	**: 0524320087**		

Network : Green

Direct Access SP

CONSULTATION	LAB/RADIOLOGY	PHYSIO	PHARMACY	IP	MATEF
10% max	NIL	NIL	NIL LIMIT	NIL	10%

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

Chief Complaints : pc : left ear pain hopc : pt came with left ear pain for the last three days o/e ear is hyperemic and filled with wax . no past medical and surgical history **Duration:**

Vitals: Temp : 36.4 Bp :144 Pulse :76 Resp :18

Clinical Findings:

Diagnosis: H61.22 - Impacted cerumen, left ear,H92.02 - Otalgia, left ear,R52 - Pain, unspecified, **Date of Onset**

Requested Investigations: 69210, RMVL IMPACTED CERUMEN SPX 1/BOTH EARS,9, Consultation GP **Estimated Cost :**

Prescriptions: 0003-281701-0241 - (BENZOCAINE : 1.4%) (TYROTHRICIN : 0.05%) (ANTIPYRINE : 5%) (HEXYLRESORCINOL : 0.10%) EAR DROPS,2593-163001-0241 - (DOCUSATE : 0.5%) EAR DROPS, **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 Healthca Employer or other organization regarding my medical condition determining insurance benefits.

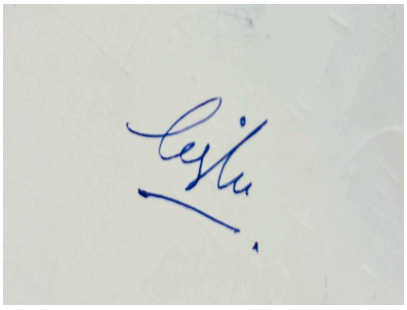
Dr's Name : AISHA

Stamp :

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

Patient 's signature{Parent if minor} :

Signature :



Date : 11-Jul-2025