Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	**: HARISON NDAIRIHO KULE**	**Service Date**	**:10-Aug-2025** **Network** : Green
Card No	**: I035-029-122758921-01**	**Health Provider**	**:CITICARE MEDICAL CENTER LLC** **Direct Access SP - YES**
Policy Holder	**: HARISON NDAIRIHO KULE**	**Doctor's Name**	**:DR Amaizah**
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-Feb-1995**		
Patient's Tel No	**: 0543020949**		

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 : sevre epigstric pain and burning and nausea , with vomitting and reflux of food loss of appetite for 1 month loose stool syated 09/08/25 o/e : look pale , lethagic tendr epigastric **Duration:**

Vitals: Temp : 36.2 Bp :120 Pulse :81 Resp :18

Clinical Findings:

Diagnosis: K29.00 - Acute gastritis without bleeding,R11.2 - Nausea with vomiting, unspecified,R19.7 - Diarrhea, unspecified,K21.9 - Gastro-esophageal reflux disease without esophagitis, **Date of Onset** :10/58/2025

Requested Investigations: 0005-174202-0781, RISEK 40MG,87338, IAAD EIA HPYLORI STOOL,85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,96360, HYDRATION IV INFUSION INIT,96374, THER/PROPH/DIAG INJ IV PUSH,9, Consultation GP,0439-152905-1001, LACTATED RINGERS INJECTION USP **Estimated Cost** :

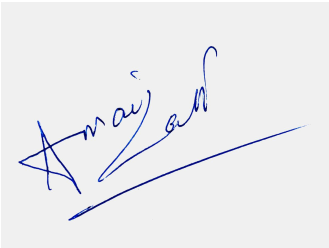
Prescriptions: **Estimated Cost** :

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 : DR Amaizah **Stamp :**

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

Signature :  **Date** : 10-Aug-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** : 10-Aug-2025