

ADMINISTRATIVE		The member is allowed for		Out-Patient		at the		Peshawar Medical Centre							
Patient Name: DINNAH KERUBO MATURI		Gender: Female		Validity Between: 17/Oct/2023and31/May/2024											
Card No: EAFB6CC8B6285E47		DOB: 03/Feb/1993		Coverage Information for: Out-Patient											
Pin #: 784-1993-8694328-8		Identity Card: 784-1993-8694328-8		Network: OP @ PCP & Sp Referral @ RN3 (S)											
National ID: 784-1993-8694328-8		Service Date: 29-Oct-2023 09:28:28 PM		Radiology: Co-Part: 20%											
Regulator Member ID: I040-002-119715119-01		Patient's Tel No: 97144478255													
Policy Holder: STRIVE RESIDENTIAL		Threshold Limit:													
Payer Name: SERVICES - FZE - CAT D		Class: B													
INS040 - Union Insurance															
Company P.J.S.C.															
Category: Category D		Out-Patient :													
Gatekeeper: No		Patient's File No:		Pharmacy: Co-Part: 30%											
		Consultation : Co-Part: 20%													
				Laboratory: Co-Part: 20%											
Referral No:															
Referred Service:															
SUBJECTIVE ASSESSMENT															
Symptom(s) as described by the patient (Chief Complaint):						Date of Symptoms/illness started									
						DD MM YYYY									
Past Medical Surgical History? ☐ YES ☐ NO						Date of Symptoms/illness started									
						DD MM YYYY									
Obs/Gyn Claims						Date of Symptoms/illness started									
Para: ☐ Gravida: ☐ AB: ☐ LMP: Marital Status: Marital Date:						DD MM YYYY									
OBJECTIVE ASSESSMENT															
Clinical Findings:				Vital Signs:		B/P		T		HR		RR			
Assessment / Diagnosis:		☐ Acute ☐ Chronic ☐ Confirmed ☐ Suspected													
		Indicate diagnosis not symptom													
1.															
2.															
ACCIDENT/OCCUPATIONAL Claim Information (complete if claim is a result of accident or work related illness/injury)															
Accident or illness due to work?				Injury due to road accident?				Describe how the accident or work related injury/illness occur:							
☐ YES ☐ NO				☐ YES ☐ NO											
Date of accident or beginning of illness:				DD		MM		YYYY							
MEDICAL PLAN Itemized Original Invoices and Applicable Prescriptions/Reports/Results must be enclosed to consider the claim															
☐ Pharmacy:				Estimated Costs				☐ Laboratory / Radiology:				Estimated Costs			
Is the following required		☐ Surgery:		☐ Endoscopy:											
		☐ Physiotherapy:		☐ Other Procedures:											
				If yes please specify											
Is In-patient Required? Length of stay				_____ days		Indicate Provider:				Estimated Cost:					
I hereby certify that all information mentioned are correct & that the medical services shown on this form were medically indicated & necessary for the management of this case.						I hereby authorize any Healthcare Provider, Insurer, Employer or other Organization to release any information regarding my medical condition and history to NEXTCARE for the purpose of determining insurance benefits. Medical management is the sole responsibility									
Treating Physician Name:															
Tel / Fax (important):		Date:		DD / MM / YYYY											
Signature & Stamp						Patient's Signature (parent if minor)				Date:		DD MM YYYY			
Note: Claims must be submitted along with supporting documents within 30 days from date of service															