Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	: **APRIL ROSE CABATO NUERA**	**Service Date**	:**29-Feb-2024**
Card No	: **I011-029-116777370-01**	**Health Provider**	:**Irham Medical Center Arjan**
Policy Holder	: **APRIL ROSE CABATO NUERA**	**Doctor's Name**	:**Sajid Sanaullah**
Payer Name	: **AL SAGR NATIONAL INSURANCE COMPANY**	**Co-Insurance**	:
TPA	: **E CARE - Blue Network**	**Remarks**	:
Validity	: **01-01-1900** To **19-05-2024**		
Gender	: **Female**		
Date Of Birth	: **24-Apr-1986**		
Patient's Tel No	: **0551443084**		

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 : FOR FOLLOWUP KNOWN HYPERTENSIVE ON VALSARTAN 80MG **Duration :**

Vitals: Temp : 36.7 Bp :120 Pulse :82 Resp :22

Clinical Findings:

Diagnosis: I10 - Essential (primary) hypertension, **Date of Onset** : 29/47/2024

Requested Investigations: 9, 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.

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.

Dr's Name : Sajid Sanaullah **Stamp :**

Dr. Sajid Sanaullah Khan
General Practitioner
DHA No: 05758224-001
PESHAWAR MEDICAL CENTER LLC
DUBAI - U.A.E.

Patient 's signature{Parent : if minor}

Date : 29-Feb-2024

Signature :

Date : 29-Feb-2024