Administrative

MEDICAL CLAIM FORM

Claim Ref :J-178942/2023

Patient Name	:SAYANTAN BARIK	**Service Date**	: 02-Apr-2023	**Network**	: Green
Card No	:I017-029-117490451-02	**Health Provider**	: Peshawar Medical Centre-Al Barsha	**Direct Access SP - YES**	
Policy Holder	:IFA HI TRUNK FZE-	**Doctor's Name**	: Tahniyat Iqbal		
Payer Name	:ABU DHABI NATIONAL INSURANCE COMPANY	**Co-Insurance**	:		
TPA	:E CARE INTERNATIONAL MEDICAL BILLING SERVICES				
Validity	:01-Oct-2022 - To - 30-Sep-2023	**Remarks**	:		
Gender	:Male				
Date Of Birth	:04-Nov-1996				
Patient's Tel No	:971-50-2648924				

CONSULT	LAB/RAD	PHYSIO	PHARMAC	IP	MATERN	DENTAL
10% upto	NIL	NIL	NIL LIMIT	NIL	10%	NA

☐ Acute ☐ Pre-existing and chronic ☐ Maternity

Chief Complaints:

Duration:

Vitals: BP: TEMP: HR: RR:

Clinical Findings:

Diagnosis:

Diagnosis Code:

Date of Onset :

(dd/mm/yyyy)

Requested Investigations:

Estimated Cost:

Prescription:	Dose:	Duration:	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: *Stamp :*

Signature : *Date :*

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 :*