Print Date/Time : 18-May-2022 6:47:06PM

Administrative

MEDICAL CLAIM FORM

Claim Ref :J-600744/202

Patient Name	:SATISH KUMAR JAGANNA SHETTY	Service Date	: 18-May-2022	Network	: Blue
Card No	:I014-029-116988761-01	Health Provider	: Peshawar Medical Centre-Al Barsha	Direct Access SP - NO	
Policy Holder	:SIGNATURE 1 HOTEL..	Doctor's Name	: RUBNA JASEEM		
Payer Name	:RAK INSURANCE	Co-Insurance	:		
TPA	:E CARE INTERNATIONAL MEDICAL BILLING SERVICES				
Validity	:10-Oct-2021 - To - 09-Oct-2022	Remarks	:		
Gender	:Male				
Date Of Birth	:22-Aug-1973				
Patient's Tel No	:971-50-1464801				

CONSULT	LAB/RAD	PHYSIO	PHARMAC IP	MATERN	DENTAL
20% upto	10%	10%	10% LIMI NIL	10%	NA

☐ Acute ☐ Pre-existing and chronic ☐ Maternity

Chief Complaints: K/c/o HTN, Type II DM
c/o tiredness, palpitations - 2wks.

Duration:

Vitals: BP: 170/104 mmHg TEMP: 36.2 °C HR: 88/m RR: 18/m SpO_2 98.1

Clinical Findings: wt- 73
Ht- 169

Diagnosis:

Diagnosis Code: I10.
E11.9, R82.90
F87.8, Z13.220, R00.2

Date of Onset : (dd/mm/yyyy)

Requested Investigations: HbA1C.
Creatinine
UR/E
K+, Na+
Triglycerides, cholesterol.

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: Dr. Rubna Jaseem
General Practitioner
DHA No: 77233809.001

Signature : Stamp : PESHAWAR MEDICAL CENTER LLC DUBAI - U.A.E.

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 : 18/05/2022