Administrative

MEDICAL CLAIM FORM

Claim Ref :J-621712/2022

Patient Name	:ERANDA PRIYADARSHANA ALUTHWALAGE	Service Date	: 30-May-2022
Card No	:I017-029-116122226-01	Health Provider	: Peshawar Medical Centre-Al Barsha
Policy Holder	:IFA HI TRUNK FZE -	Doctor's Name	: Saiqa Younis
Payer Name	:ABU DHABI NATIONAL INSURANCE COMPANY	Co-Insurance	:
TPA	:E CARE INTERNATIONAL MEDICAL BILLING SERVICES		
Validity	:01-Oct-2021 - To - 30-Sep-2022	Remarks	:
Gender	:Male		
Date Of Birth	:17-Mar-1992		
Patient's Tel No	:971-55-3673847		

Network : Green

Direct Access SP - YES

CONSULT LAB/RAD	PHYSIO	PHARMACY IP	MATERN	DENTAL
10% max NIL	NIL	NIL LIMIT NIL	10%	NA

☐ Acute ☐ Pre-existing and chronic ☐ Maternity

Chief Complaints:

Loss of sensation in finger

Duration:

1 week ago

Vitals: BP: 130/70 TEMP: 37°C HR: 84 c RR: 18/m Wt:- 59 kg/Ht:- 163 cm. SPO_2:-

Clinical Findings:

No abnormaly detected

Diagnosis:	Diagnosis Code:	Date of Onset :
Unspecified disturbance of skin sens.	R20.9	1 week ago (dd/mm/yyyy)
Oth disturbances of skin sensatn	R20.8	

Requested Investigations:

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Estimated Cost:

Prescription:	Dose:	Duration:	Estimated Cost:
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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: Saiqa Younis

Signature : *Stamp* *Date :*

Dr. Saiqa Younis
General Practitioner
DHA No: 0017903
PESHAWAR MEDICAL CENTER LLC
DUBAI - U.A.E.

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 : 30-5-22