Print Date/ Time : 31-May-2022 2:48:37PM

Administrative

MEDICAL CLAIM FORM

Claim Ref :J-623005/2022

Patient Name	:FATIMAH BINTI SAR	Service Date	: 31-May-2022
Card No	:I014-029-117681854-01	Health Provider	: Peshawar Medical Centre-Al Barsha
Policy Holder	:STAYBRIDGE SUITES FC L.L.C-	Doctor's Name	: Saiqa Younis
Payer Name	:RAK INSURANCE	Co-Insurance	:
TPA	:E CARE INTERNATIONAL MEDICAL BILLING SERVICES		
Validity	:03-Jan-2022 - To - 02-Jan-2023	Remarks	:
Gender	:Female		
Date Of Birth	:23-Apr-1995		
Patient's Tel No	:971-58-6268482		

Network : Blue

Direct Access SP - NO

CONSULT LAB/RAI	PHYSIO	PHARMAC IP	MATERN	DENTAL
20% max NIL	NIL	NIL Max 5	NIL 10%	NA

☐ Acute ☐ Pre-existing and chronic ☐ Maternity

Chief Complaints:

fever
Headache
Cough
nasal congestion

Duration:

one day duration

Vitals: BP: 115/85mmHg TEMP: 38°C HR: 76b/mt RR: 20b/mt

Clinical Findings:

N

Diagnosis:

Acute upper respiratory tract infectn
fever
Cough

Diagnosis Code:

J06.9
R50.9
R05

Date of Onset :

one day duration

(dd/mm/yyyy)
31/5/22

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. Saiqa Younis
General Practitioner
DHA No: 00177613-003
PESHAWAR MEDICAL CENTER LLC
DUBAI - U.A.E.

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 : 31-5-22