Administrative

MEDICAL CLAIM FORM

Claim Ref :J-636041/2022

Patient Name	:AMILA SANJEEWA ARANGALA	Service Date	: 07-Jun-2022
Card No	:I017-029-118013017-01	Health Provider	: Peshawar Medical Centre-Al Barsha
Policy Holder	:IFA HI TRUNK FZE -	Doctor's Name	: SAJID RASHID(HNC MDC)
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	:04-Nov-1984		
Patient's Tel No	:971-52-5330648		

Network : Green

Direct Access SP - YES

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

☐ Acute ☐ Pre-existing and chronic ☐ Maternity

Chief Complaints: Chest pain, Indigestion 7 day/DAY

Duration:

Vitals: BP: 110/70mm/Hg TEMP: 36C HR: 82 b/mt RR: 20 b/mt

Clinical Findings:

Diagnosis: R 53-82 I10 7-9 K59.00

Diagnosis Code:

Date of Onset : (dd/mm/yyyy)

Requested Investigations: ECG - TSH - Lipid panel, CBC

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. Sajid Sanaullah Khan
General Practitioner
DHA No: 05758224-001
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 :* 07-06-22

For Clinic & Hospital Approval : **043811550** | For Pharmarcy Approval : **043811560**