

ADMINISTRATIVE

The member is allowed for

Out-Patient

at the Peshawar Medical Centre

Patient Name:	ANOOP PARAMMEL GOVINDA	Gender:	Male	Validity Between:	19/Jun/2021 and 18/Jun/2022
Card No:	F2EC7426D0BADD95	DOB:	27/Apr/1991	Coverage Information for:	Out-Patient
Pin #:		Identity Card	784-1991-9599549-5	Network:	OIC-RN2 UAE Only
National ID:	784-1991-9599549-5	Service Date:	07-Jun-2022 05:55:06 PM	Radiology:	Covered
Regulator Member ID:	I008-002-116330295-01	Patient's Tel No:	971564976137		
Policy Holder:	AL DHAHERI CAPITAL	Threshold Limit:			
Payer Name:	INVESTMENT LLC INS008 - Orient Insurance PJSC	Class:	A		
Category:	CAT B1-EX	Out-Patient :			
Gatekeeper:	No	Patient's File No:		Pharmacy:	Covered
		Consultation : Co-Part: 20% Max(50 AED)		Laboratory:	Covered
Referral No:					
Referred Service:					

SUBJECTIVE ASSESSMENT

Symptom(s) as described by the patient (Chief Complaint):		Date of Symptoms/illness started	
BAD Fever & Cold Cough Gout Negative RUNNY Nose		DD MM YYYY	
Past Medical Surgical History?	☐ YES ☐ NO	Date of Symptoms/illness started	
No Cough Ahead 3-4		DD MM YYYY	
Obs/Gyn Claims		Date of Symptoms/illness started	
Para: ☐ Gravida: ☐ AB: ☐ LMP:	Marital Status:	Marital Date:	
Mom BP ↑		DD MM YYYY	

OBJECTIVE ASSESSMENT

Clinical Findings:	Vital Signs:	B/P	120/70	T	38.1C	HR	84b/min	RR	20b/min
Assessment / Diagnosis:	☐ Acute ☐ Chronic ☐ Confirmed ☐ Suspected Indicate diagnosis not symptom								
1.	URTI								
2.	Cough								

ACCIDENT/OCCUPATIONAL Claim Information (complete if claim is a result of accident or work related illness/injury)

Accident or illness due to work?	Injury due to road accident?	Describe how the accident or work related injury/illness occur:
☐ YES ☐ NO	☐ YES ☐ NO	
Date of accident or beginning of illness:	DD MM YYYY	

MEDICAL PLAN Itemized Original Invoices and Applicable Prescriptions/Reports/Results must be enclosed to consider the claim

☐ Pharmacy:	Antibiotics, Soory D/ 250 DL-DS	Estimated Costs	☐ Laboratory / Radiology:	CBC electrolytes	Estimated Costs
Is the following required	☐ Surgery: ☐ Endoscopy: ☐ Physiotherapy: ☐ Other Procedures: If yes please specify				
Is In-patient Required?	Length of stay	days	Indicate Provider:	Estimated Cost:	
I hereby certify that all information reported is correct & that the medical services shown on this form were rendered by the General Practitioner & necessary for the management of this case.			I hereby authorize any Healthcare Provider, Insurer, Employer or other Organization to release any information regarding my medical condition and history to NEXCARE for the purpose of determining insurance benefits. Medical management is the sole responsibility of doctor and the patient.		
Treating Physician Name: Dr. Sajid Samad Khan General Practitioner DHA No: 05758224-001 PESHAWAR MEDICAL CENTER LLC DU, Peshawar, A.E.			Signature & Stamp: [Signature] Date: 07/06/22		
Tel / Fax (important): Signature & Stamp: [Signature] Date: 07/06/22			Patient's Signature (parent if minor) Date: 07/06/22		

Note: Claims must be submitted along with supporting documents within 30 days from date of service