Print Date/ Time : 07-Jun-2022 8:13:36PM

Administrative

MEDICAL CLAIM FORM

Claim Ref :J-636576/2022

Patient Name	:PAULINE NDAULA	Service Date	: 07-Jun-2022	Network	: Green
Card No	:I017-029-118146408-01	Health Provider	: Peshawar Medical Centre-Al Barsha	Direct Access SP - YES	
Policy Holder	:MOVENPICK HOTEL JUMEIRAH LAKES TOWERS-	Doctor's Name	: Sajid Sanaullah Khan		
Payer Name	:ABU DHABI NATIONAL INSURANCE COMPANY	Co-Insurance	:		
TPA	:E CARE INTERNATIONAL MEDICAL BILLING SERVICES	Remarks	:		
Validity	:01-Oct-2021 - To - 30-Sep-2022				
Gender	:Female				
Date Of Birth	:19-Feb-1991				
Patient's Tel No	:971-52-1955884				

CONSULT	LAB/RAD	PHYSIO	PHARMAC IP	MATERN	DENTAL
10% max	NIL	NIL	NIL Max 1 NIL	10%	NA

☐ Acute ☐ Pre-existing and chronic ☐ Maternity

Chief Complaints: ARM PAIN in bilat Shoulders 7/12 2018 STRESSED
Walks as housekeeping
No Smoke Nor Alcohol
HEADACHE

Duration: A C Makes it worse
Mom BP

Vitals: BP: 120/80mmHg TEMP: 36.6°C HR: 78 b/mt RR: 18/mt Wt=61.4kg Ht= 171cm

Clinical Findings:

Diagnosis: Repeated Stress Injury Headache

Diagnosis Code:

Date of Onset : (dd/mm/yyyy)

Requested Investigations: ECG CBC & Electrolytes TSH Lipid Panel

Estimated Cost:

Prescription:	Dose:	Duration:	Estimated Cost:
~~PANT~~ 1 Diclofenac 75mg OD 2 Famotidine 40mg BD			

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: *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 :*