Administrative

MEDICAL CLAIM FORM

Claim Ref :J-639726/2022

Patient Name	:Mutyala Naidu Paravada	**Service Date**	: 09-Jun-2022
Card No	:I008-029-118095490-01	**Health Provider**	: Peshawar Medical Centre-Al Barsha
Policy Holder	:Grand Plaza Movenpick Hotel FZ-LLC.	**Doctor's Name**	: Sajid Sanaullah Khan
Payer Name	:ORIENT INSURANCE P.J.S.C	**Co-Insurance**	:
TPA	:E CARE INTERNATIONAL MEDICAL BILLING SERVICES		
Validity	:14-Jun-2021 - To - 13-Jun-2022	**Remarks**	:
Gender	:Male		
Date Of Birth	:16-Jun-1996		
Patient's Tel No	:971-54-7931419		

Network : Blue

Direct Access SP - NO

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

☐ Acute ☐ Pre-existing and chronic ☐ Maternity

Chief Complaints:

Eyes Burning
fatigue
Smoke No
Alcohol - 1/week

Duration:

Vitals: BP: TEMP: HR: RR:

Clinical Findings:

Diagnosis:

Diagnosis Code:

Date of Onset : (dd/mm/yyyy)

Requested Investigations:

CBC, electrolytes, Lipid Profile
TSH

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's Name: Dr. Sajid Sanaullah Khan

Signature : *Stamp:* *Date :*

Dr. Sajid Sanaullah Khan
General Practitioner
DHA No: 0575884-001
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 :*

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