Administrative

MEDICAL CLAIM FORM

Claim Ref :J-641505/2022

Patient Name	: NISHANTHA BANDARANAYAKA MUDIYANSELAGE	Service Date	: 10-Jun-2022	Network	: Green
Card No	: 1017-029-116122149-01	Health Provider	: Peshawar Medical Centre-Al Barsha		Direct Access SP - YES
Policy Holder	: IFA HI TRUNK FZE -	Doctor's Name	: Sajid Sanaullah Khan		
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	: 22-Nov-1989				
Patient's Tel No	: 971-52-8867477				

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: Sore Throat Cough x 3 days
Fever
PCR

Duration:

Vitals: BP: 120/66mmHg TEMP: 37C HR: 56b/mt RR: 20b/mt.

Clinical Findings: Exudates Throat
Height - 168cm
weight - 75.8Kg

Diagnosis: Acute T I

Diagnosis Code:

Date of Onset : (dd/mm/yyyy)

Requested Investigations: PCR
CBC,

Estimated Cost:

Prescription: Amoxicillin 500mg TID x 7 days

Dose:

Duration:

Estimated Cost:

Dr. Sajid Sanaullah Khan
General Practitioner
DHA No. 58224-001
PESHAWAR MEDICAL CENTER LLC
DUBAI, U.A.E.

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 :* 10/6/2022