Administrative

MEDICAL CLAIM FORM

Claim Ref :J-642153/2022

Patient Name	:BELINDA WANLEM LANGCHIANG	Service Date	: 10-Jun-2022	Network	: Green
Card No	:I017-029-116122269-01	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	: CONSULT LAB/RAD PHYSIO PHARMAC IP MATERN DENTAL 10% max NIL NIL NIL LIMIT NIL 10% NA		
TPA	:E CARE INTERNATIONAL MEDICAL BILLING SERVICES				
Validity	:01-Oct-2021 - To - 30-Sep-2022	Remarks	:		
Gender	:Male				
Date Of Birth	:24-Jun-1985				
Patient's Tel No	:971-56-8873416				

☐ Acute ☐ Pre-existing and chronic ☐ Maternity

Chief Complaints: Red eye ~~Cong~~
No Smoking
No Alcohol

Duration:

Vitals: BP: 100/70 mmHg TEMP: 36.8°C HR: 74 b/mt RR: 18 b/mt Wt 63.9kg Ht 165cm

Clinical Findings:

Diagnosis: Conjunctivitis
BACTERIAL

Diagnosis Code:

Date of Onset : (dd/mm/yyyy)

Requested Investigations:

Estimated Cost:

Prescription:	Dose:	Duration:	Estimated Cost:
Ciprofloxacin eye drops QID " Ointment at night			

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 :* 10-06-22