Administrative

MEDICAL CLAIM FORM

Claim Ref :J-642295/2022

Patient Name	:SWATI SHARMA RAJ KUMAR SHARMA	Service Date	: 10-Jun-2022	Network	: Blue
Card No	:I014-029-117763279-01	Health Provider	: Peshawar Medical Centre-Al Barsha	Direct Access SP - NO	
Policy Holder	:STAYBRIDGE SUITES FC L.L.C-	Doctor's Name	: Sajid Sanaullah Khan		
Payer Name	:RAK INSURANCE	Co-Insurance	: CONSULT LAB/RAD: 20% max NIL; PHYSIO: NIL; PHARMAC IP: NIL Max 5; MATERN: 10%; DENTAL: NA		
TPA	:E CARE INTERNATIONAL MEDICAL BILLING SERVICES				
Validity	:03-Jan-2022 - To - 02-Jan-2023	Remarks	:		
Gender	:Female				
Date Of Birth	:24-Sep-2000				
Patient's Tel No	:971-56-2747787				

☐ Acute ☐ Pre-existing and chronic ☐ Maternity

Chief Complaints: Sore throat x 2 days, Work at hotel, fever – 99'8, Cough

Duration:

Vitals: BP: 100/70 mmHg TEMP: 36.9°C HR: 78/m RR: 22/m Wt 63.8kg Ht 169 cm SpO2 96%

Clinical Findings:

Diagnosis: URTI

Diagnosis Code:

Date of Onset : (dd/mm/yyyy)

Requested Investigations: PCR, CBC, Electrolytes, Lipid Profile, BH

Estimated Cost:

Prescription:	Dose:	Duration:	Estimated Cost:
– AZITHROMYCIN 250mg OD		x 5 days	
– MUCIPLEX 5ml	TID	x 5 days	

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: 05756224-001
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 : 10-6-22

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