MEDICAL CLAIM FORM

Claim Ref :J-642407/2022

Administrative

Patient Name	:LIEZEL SUICO DESABILLE	Service Date	: 10-Jun-2022	Network	: Blue
Card No	:I014-029-113719145-04	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	:		
TPA	:E CARE INTERNATIONAL MEDICAL BILLING SERVICES				
Validity	:03-Jan-2022 - To - 02-Jan-2023	Remarks	:		
Gender	:Female				
Date Of Birth	:19-Oct-1974				
Patient's Tel No	:971-56-7312820				

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: Chest pain HTN

Duration:

Vitals: BP: 170/100mmHg TEMP: 37C HR: 70/m RR: 22/m SPO2 97%.

Clinical Findings:

Diagnosis: Chest PAIN HTN

Diagnosis Code:

Date of Onset : (dd/mm/yyyy)

Requested Investigations: ECG

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. Sajid Sanaullah Khan
General Practitioner
DHA No: 0575022-001
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} : Liezel S. Desabille *Date :* 10-06-22