Print Date/ Time : 11-Jun-2022 11:42:35AM

Administrative

MEDICAL CLAIM FORM

Claim Ref :J-634311/2022

Patient Name	:STANISLAUS LAWRENCE LOBO	Service Date	: 06-Jun-2022	Network	: Blue
Card No	:I014-029-116223078-01	Health Provider	: Peshawar Medical Centre-Al Barsha	Direct Access SP - NO	
Policy Holder	:SIGNATURE 1 HOTEL..	Doctor's Name	: Sajid Sanaullah Khan		
Payer Name	:RAK INSURANCE	Co-Insurance	: CONSULT LAB/RAD PHYSIO PHARMAC IP MATERN DENTAL 20% upto 10% 10% 10% LIMI NIL 10% NA		
TPA	:E CARE INTERNATIONAL MEDICAL BILLING SERVICES				
Validity	:10-Oct-2021 - To - 09-Oct-2022	Remarks	:		
Gender	:Male				
Date Of Birth	:18-Feb-1974				
Patient's Tel No	:971-55-9413374				

☐ Acute ☐ Pre-existing and chronic ☐ Maternity

Chief Complaints: Sore Throat, Fever, Body aches, ~~NKDA~~ Allergy Bruffen - RASH

Duration:

Vitals: BP: 135/77mmHg TEMP: 37°C HR: 104/m RR: 23/m WT 64.5 HT 170cm ~~SPO2~~ SPO2 95%

Clinical Findings: Exudates in Throat

Diagnosis: URTI

Diagnosis Code:

Date of Onset : (dd/mm/yyyy) x 2 days

Requested Investigations:

Estimated Cost:

Prescription:	Dose:	Duration:	Estimated Cost:
- Amoxicillin 500mg TDS x	Days		
- Mucopectil 5ml TD x		7 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: 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 : 11-06-22