Administrative

MEDICAL CLAIM FORM

Claim Ref :J-648890/2022

Patient Name	:VIJAYDATTA PANDURANG DEORE	Service Date	: 14-Jun-2022	Network	: Green
Card No	:I017-029-116896797-01	Health Provider	: Peshawar Medical Centre-Al Barsha		Direct Access SP - YES
Policy Holder	:IFA HI TRUNK FZE -	Doctor's Name	: SAJID RASHID(HNC MDC)		
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	:20-Feb-1986				
Patient's Tel No	:971-52-5448561				

☑ Acute ☐ Pre-existing and chronic ☐ Maternity

Chief Complaints: Cramps in thumb No fever No Diarrhea No Vomiting Constipation He ate outside last night ~~He~~ smoked No Alcohol

Duration: X 1 DAY

Vitals: BP: 120/80 TEMP: 36.7c HR: 76b/m RR: 18b/m SPO_2 99

Clinical Findings:

Diagnosis: Gastro enteritis

Diagnosis Code:

Date of Onset : (dd/mm/yyyy)

Requested Investigations:

Estimated Cost:

Prescription:	Dose:	Duration:	Estimated Cost:
Inj Buscopan I.M.			

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 :* 14/6/2022