Administrative

MEDICAL CLAIM FORM

Claim Ref :J-649576/2022

Patient Name	:LEAH MARCELO APOSTOL	Service Date	: 14-Jun-2022
Card No	:I017-029-116125800-01	Health Provider	: Peshawar Medical Centre-Al Barsha
Policy Holder	:IFA HI TRUNK FZE -	Doctor's Name	: Sajid Sanaullah Khan
Payer Name	:ABU DHABI NATIONAL INSURANCE COMPANY	Co-Insurance	:
TPA	:E CARE INTERNATIONAL MEDICAL BILLING SERVICES		
Validity	:01-Oct-2021 - To - 30-Sep-2022	Remarks	:
Gender	:Female		
Date Of Birth	:06-May-1978		
Patient's Tel No	:971-52-5696874		

Network : Green

Direct Access SP - YES

CONSULT LAB/RAD	PHYSIO	PHARMAC IP	MATERN	DENTAL
10% max NIL	NIL	NIL LIMIT NIL	10%	NA

44

☐ Acute ☐ Pre-existing and chronic ☐ Maternity

Chief Complaints: Rt elbow 9/10 Redness, to dm, Rest L Repetitive Stress injury

Duration:

Vitals: BP: 110/90 mm/Hg TEMP: 36.4°C HR: 74 b/mt RR: 20 b/mt

Clinical Findings: Rt elbow

Diagnosis: RSI

Diagnosis Code:

Date of Onset : (dd/mm/yyyy)

Requested Investigations: CBC Electrolytes TSH Lipid Profile

Estimated Cost:

Prescription:

- ~~Inj DEXA~~
- ATORVA

Dose:	Duration:	Estimated Cost:

Dr. Sajid Sanaullah Khan
General Practitioner
DHA No: 05758224-001
PESHAWAR MEDICAL CENTER LLC
DUBAI - U.A.E.

MEDICAL PRACTITIONER DECLARATION :

I declare that I am the patient's medical practitioner and 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 : 14/06/2022