

Administrative

MEDICAL CLAIM FORM

Claim Ref : J-640595/2022

Patient Name	: GRETCHEN PACARAT	Service Date	: 09-Jun-2022	Network	: Green
Card No	: I017-029-116280045-01	Health Provider	: Peshawar Medical Centre-Al Barsha	Direct Access SP - YES	
Policy Holder	: IFA HI TRUNK FZE -	Doctor's Name	: Sajid Sanaulah Khan		
Payer Name	: ABU DHABI NATIONAL INSURANCE COMPANY	Co-Insurance	: CONSULT LAB/RAC	PHYSIO	PHARMAC IP
TPA	: E CARE INTERNATIONAL MEDICAL BILLING SERVICES		10% max NIL	NIL	NIL LIMIT NIL
Validity	: 01-Oct-2021 - To - 30-Sep-2022	Remarks	:	MATERN DENTAL	10% NA
Gender	: Female				
Date Of Birth	: 22-Dec-1985				
Patient's Tel No	: 971-54-5432908				

☐ Acute☐ Pre-existing and chronic☐ Maternity

Chief Complaints:

Duration:

Vitals: BP: 100/70 mm/Hg TEMP: 37.1°C HR: 76b/min RR: 18b/min

Clinical Findings:

Diagnosis:

Diagnosis Code:

Date of Onset :

(dd/mm/yyyy)

Requested Investigations:

Estimated Cost:

Prescription:

Dose:

Duration:

Estimated Cost:

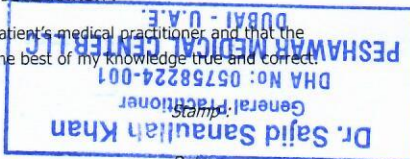
Inj DEXA
2 DAYS leave

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:

Signature :



Stamp:

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