Administrative

MEDICAL CLAIM FORM

Claim Ref :J-649981/2022

Patient Name	:DILAN SAMLAKA	Service Date	: 14-Jun-2022	Network	: Green
Card No	:I017-029-117490343-01	Health Provider	: Peshawar Medical Centre-Al Barsha	Direct Access SP - YES	
Policy Holder	:IFA HI TRUNK FZE -	Doctor's Name	: Sajid Sanaullah Khan		
Payer Name	:ABU DHABI NATIONAL INSURANCE COMPANY	Co-Insurance	: CONSULT LAB/RAD: 10% max NIL; PHYSIO: NIL; PHARMAC IP: NIL LIMIT NIL; MATERN: 10%; DENTAL: NA		
TPA	:E CARE INTERNATIONAL MEDICAL BILLING SERVICES				
Validity	:01-Oct-2021 - To - 30-Sep-2022	Remarks	:		
Gender	:Male				
Date Of Birth	:18-Sep-1990				
Patient's Tel No	:971-52-2946517				

31y

☐ Acute ☐ Pre-existing and chronic ☐ Maternity

Chief Complaints:

~~New~~ Cough x 4 DAYS Sputum with blood
x Smoker
Alcohol - 2/month No Fever
PAIN 10/10

Duration: X 4 DAYS

Vitals: BP: 140/70 mm/Hg TEMP: 37.2°C HR: 86b/mt RR: 20b/mt

Clinical Findings:

Diagnosis: Rt ear otitis

Diagnosis Code:

Date of Onset : (dd/mm/yyyy)

Requested Investigations: CBC, electrolytes, Lipid Profile
FBS

Estimated Cost:

Prescription: Cap Pantoday
Injection Diclofenac IM

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

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} : Dilan *Date :* 14/06/2022