Administrative

MEDICAL CLAIM FORM

Claim Ref :J-650223/2022

Patient Name	:DAVEED FRANCIS THEKKEVILATHARAYIL	Service Date	: 14-Jun-2022
Card No	:I017-029-116524270-01	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	:Male		
Date Of Birth	:01-Jun-1961		
Patient's Tel No	:971-50-7647201		

Network : Green

Direct Access SP - YES

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

62

☐ Acute ☐ Pre-existing and chronic ☐ Maternity

Chief Complaints: Shoulder pain X 2 - 3Mo
>/10 Only on Sleeping time
No Radiation No Injury No Accident

Duration: 2 - 3 Mo

Vitals: BP: 150/90 mmHg TEMP: 37C HR: 74b/mt RR: 18b/mt

Clinical Findings:

Diagnosis: HTN
Hyperlipid

Diagnosis Code:

Date of Onset : (dd/mm/yyyy)

Requested Investigations: CBC, Lipid, FBS, Electrolytes
ECG

Estimated Cost:

Prescription:	Dose:	Duration:	Estimated Cost:
- ATORVA 10	mg	OD	
- HCTZ			

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 :

Dr. Sajid Sanaullah Khan
General Practitioner
DHA No: 057562240 001
PESHAWAR MEDICAL CENTER LLC
DUBAI - U.A.E.

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