

## Administrative

## MEDICAL CLAIM FORM

Claim Ref : J-651041/2022

|                  |                                                 |                 |                                     |                       |               |
|------------------|-------------------------------------------------|-----------------|-------------------------------------|-----------------------|---------------|
| Patient Name     | : TWINKLE RAJ KUMAR                             | Service Date    | : 15-Jun-2022                       | Network               | : Blue        |
| Card No          | : I014-029-117469392-02                         | Health Provider | : Peshawar Medical Centre-Al Barsha | Direct Access SP - NO |               |
| Policy Holder    | : STAYBRIDGE SUITES FC L.L.C-                   | Doctor's Name   | : SAJID RASHID(HNC MDC)             |                       |               |
| Payer Name       | : RAK INSURANCE                                 | Co-Insurance    | : CONSULT LAB/RAC                   | PHYSIO                | PHARMAC IP    |
| TPA              | : E CARE INTERNATIONAL MEDICAL BILLING SERVICES |                 | 20% max NIL                         | NIL                   | NIL Max 5 NIL |
| Validity         | : 03-Jan-2022 - To - 02-Jan-2023                | Remarks         |                                     | 10%                   | NA            |
| Gender           | : Female                                        |                 |                                     |                       |               |
| Date Of Birth    | : 16-Nov-1995                                   |                 |                                     |                       |               |
| Patient's Tel No | : 971-55-2425493                                |                 |                                     |                       |               |

|                                           |                                                   |                                    |
|-------------------------------------------|---------------------------------------------------|------------------------------------|
| <input checked="" type="checkbox"/> Acute | <input type="checkbox"/> Pre-existing and chronic | <input type="checkbox"/> Maternity |
|-------------------------------------------|---------------------------------------------------|------------------------------------|

|                                                                              |           |
|------------------------------------------------------------------------------|-----------|
| Chief Complaints:                                                            | Duration: |
| - Dry Cough<br>- Fever<br>- Joint pain<br>Sore Lips<br>No Drug<br>No Alcohol | X 2 days  |

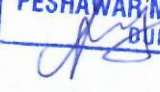
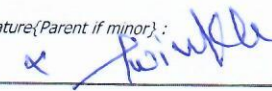
|         |          |            |           |           |
|---------|----------|------------|-----------|-----------|
| Vitals: | BP: 84/1 | TEMP: 37.1 | HR: 98b/m | RR: 18b/m |
|---------|----------|------------|-----------|-----------|

|                     |
|---------------------|
| Clinical Findings:  |
| 100/40<br>DAD-DM-SS |

|            |                 |                 |
|------------|-----------------|-----------------|
| Diagnosis: | Diagnosis Code: | Date of Onset : |
| URTI       |                 | (dd/mm/yyyy)    |

|                                             |                 |
|---------------------------------------------|-----------------|
| Requested Investigations:                   | Estimated Cost: |
| CBC<br>TSH<br>electrolytes<br>lipid profile |                 |

|               |       |           |                 |
|---------------|-------|-----------|-----------------|
| Prescription: | Dose: | Duration: | Estimated Cost: |
| Augmentin TR  |       |           |                 |

|                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                    |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| MEDICAL PRACTITIONER DECLARATION<br>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.<br>Dr's Name: Dr. Sajid Sanaullah Khan<br>Signature: <br>Date:<br>PESHAWAR MEDICAL CENTER LLC<br>DUBAI - U.A.E. | PATIENT'S DECLARATION :<br>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.<br>Patient's signature(Parent if minor): <br>Date: 15/6/2022 |
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