Print Date/ Time : 15-Jun-2022 2:51:00PM

Administrative

MEDICAL CLAIM FORM

Claim Ref :J-651316/2022

Patient Name	:MOHAMED RAMADHANI SUDI	Service Date	: 15-Jun-2022	Network	: Green
Card No	:I017-029-116122136-01	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	:		
TPA	:E CARE INTERNATIONAL MEDICAL BILLING SERVICES				
Validity	:01-Oct-2021 - To - 30-Sep-2022	Remarks	:		
Gender	:Male				
Date Of Birth	:16-Dec-1986				
Patient's Tel No	:971-55-2625872				

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

☐ Acute ☐ Pre-existing and chronic ☐ Maternity

Chief Complaints: Ruptured Hemorrhoids

Duration: No leg Mobility

Vitals: BP: 130/80 mmHg TEMP: 36°C HR: 70 b/mt RR: 18 b/mt Wt 57.6kg Ht. 170cm

Clinical Findings:

Diagnosis:

Diagnosis Code:

Date of Onset : (dd/mm/yyyy)

Requested Investigations:

Estimated Cost:

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

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 : 15/06/2022