Print Date/ Time : 15-Jun-2022 4:47:50PM

Administrative

MEDICAL CLAIM FORM

Claim Ref :J-651509/2022

Patient Name	:OBAID ASGHAR	Service Date	: 15-Jun-2022	Network	: Blue
Card No	:I014-029-118010517-01	Health Provider	: Peshawar Medical Centre-Al Barsha		**Direct Access SP - NO**
Policy Holder	:SIGNATURE 1 HOTEL..	Doctor's Name	: Sajid Sanaullah Khan		
Payer Name	:RAK INSURANCE	Co-Insurance	:		
TPA	:E CARE INTERNATIONAL MEDICAL BILLING SERVICES				
Validity	:10-Oct-2021 - To - 09-Oct-2022	Remarks	:		
Gender	:Male				
Date Of Birth	:25-Dec-1998				
Patient's Tel No	:971-56-2612459				

CONSULT	LAB/RAD	PHYSIO	PHARMACY IP	MATERN	DENTAL
20% upto	10%	10%	10% LIMI NIL	10%	NA

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☐ Acute ☐ Pre-existing and chronic ☐ Maternity

Chief Complaints: Male - DM Sore Throat Fever x2 DAYS x Smoker No Alcohol WEIGHT Loss

Duration:

Vitals: BP: 120/90 mmHg TEMP: 37°C HR: 78 b/mt RR: 18 b/mt

Clinical Findings: Exudates in Throat

Diagnosis: URTI

Diagnosis Code:

Date of Onset : (dd/mm/yyyy)

Requested Investigations: CBC, Lipid Profile, TSH, Electrolytes, ECG

Estimated Cost:

Prescription: Augmentin

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
Medical 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

For Clinic & Hospital Approval : **043811550** | For Pharmacy Approval : **043811560**

5:45 PM