Print Date/ Time : 15-Jun-2022 5:01:01PM

Administrative

MEDICAL CLAIM FORM

Claim Ref :J-651542/2022

Patient Name	:PAUL GEORGE	Service Date	: 15-Jun-2022	Network	: Green
Card No	:I017-029-117311948-01	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	:26-Jun-1995				
Patient's Tel No	:971-52-1347280				

26y

2 days Sick leave NKDA

☐ Acute ☐ Pre-existing and chronic ☐ Maternity

Chief Complaints: Body pain Cold Cough Enlarged Tongue Fever Chills 5 yrs Sputum 4 days/ Yellow/

Duration: 1 day 3-4 Drinks/day

Vitals: BP: 120/80 mmHg TEMP: 37°C HR: 86b/mt RR: 20b/mt

Clinical Findings: Chest crackles

Diagnosis: URTI

Diagnosis Code:

Date of Onset : (dd/mm/yyyy)

Requested Investigations: CBC electrolytes lipid TSH LFT's CXR

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
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

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

6:15 PM