Administrative

MEDICAL CLAIM FORM

Claim Ref :J-647007/2022

Patient Name	:AAYUSHA KARKI	Service Date	: 13-Jun-2022	Network	: Green
Card No	:I017-029-116954351-01	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	PHYSIO	PHARMAC IP	MATERN	DENTAL
10% max	NIL	NIL	NIL LIMIT NIL	10%	NA

TPA	:E CARE INTERNATIONAL MEDICAL BILLING SERVICES		
Validity	:01-Oct-2021 - To - 30-Sep-2022	Remarks	:
Gender	:Female		
Date Of Birth	:16-Oct-1999		
Patient's Tel No	:971-56-8825120		

22

☐ Acute ☐ Pre-existing and chronic ☐ Maternity

Chief Complaints:

Duration:

Vitals: BP: 100/70mmHg TEMP: 37C HR: 82b/mt RR: 18b/mt

Clinical Findings:

Diagnosis:

Diagnosis Code:

Date of Onset : (dd/mm/yyyy)

Requested Investigations:

Estimated Cost:

Prescription:	Dose:	Duration:	Estimated Cost:
ACYCLOVIR 400mg X 5 DAYS X5			

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 :* 15/6/2022