Administrative

MEDICAL CLAIM FORM

Claim Ref :J-652096/2022

Patient Name	:RINSAD ALIYAR	Service Date	: 15-Jun-2022	Network	: Green
Card No	:I017-029-117161088-01	Health Provider	: Peshawar Medical Centre-Al Barsha	**Direct Access SP - YES**	
Policy Holder	:TH8 A HOUSE OF ORIGINALS HOTEL - 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	: 244		
Gender	:Male				
Date Of Birth	:06-Sep-1992				
Patient's Tel No	:971-50-8085914		NADA		

CONSULT	LAB/RAD	PHYSIO	PHARMAC	IP	MATERN	DENTAL
10% max	NIL	NIL	NIL Max 1	NIL	10%	NA

☐ Acute ☐ Pre-existing and chronic ☐ Maternity

Chief Complaints: BACK PAIN 5/10 No radiation
Movement ↑ pain
Shoulder & Neck pain Cig - 5/DAY - Alcohol NO

Duration: 7 years

Vitals: BP: 106/60 TEMP: 36.7°C HR: 120 b/m RR: 20 b/m

Clinical Findings:

Diagnosis: BACK PAIN
Shoulder pain

Diagnosis Code:

Date of Onset : (dd/mm/yyyy)

Requested Investigations: CBC, electrolytes, BH, Lipid Profile

Estimated Cost:

Prescription:	Dose:	Duration:	Estimated Cost:
Naproxen Strong BID	x 5	Days	

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 Pharmarcy Approval : **043811560**