Print Date/ Time : 15-Jun-2022 8:03:11PM

Administrative

MEDICAL CLAIM FORM

Claim Ref :J-652184/2022

Patient Name	:BINOD KHADKA	Service Date	: 15-Jun-2022	Network	: Blue
Card No	:I014-029-114105336-02	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	:22-Apr-1990				
Patient's Tel No	:971-56-4453074				

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

32

NKDA

☐ Acute ☐ Pre-existing and chronic ☐ Maternity

Chief Complaints:

BACK PAIN x 2 DAYS 4/10
No Reduction in Activities
Housekeeping
↓ Rest
No Cig
No Alcohol

Duration:

x 2 Days

Vitals: BP: 110/70mmHg TEMP: 37C HR: 56b/mt RR: 18b/mt

Clinical Findings:

Diagnosis:

BACK PAIN

Diagnosis Code:

Date of Onset : (dd/mm/yyyy)

Requested Investigations:

CBC, electrolytes, BH
lipid Profile

Estimated Cost:

Prescription:	Dose:	Duration:	Estimated Cost:
NAPROXEN 500mg 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