Administrative

MEDICAL CLAIM FORM

Claim Ref :J-655116/2022

Patient Name	:NISHANTHA BANDARANAYAKA MUDIYANSELAGE	**Service Date**	: 17-Jun-2022	**Network**	: Green
Card No	:1017-029-116122149-01	**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**	:		
TPA	:E CARE INTERNATIONAL MEDICAL BILLING SERVICES				
Validity	:01-Oct-2021 - To - 30-Sep-2022	**Remarks**	:		
Gender	:Male				
Date Of Birth	:22-Nov-1989				
Patient's Tel No	:971-52-8867477				

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

☐ Acute ☐ Pre-existing and chronic ☐ Maternity

Chief Complaints: Fever, Cough, Headache, Chest pain

Duration: 2-3 days

Vitals: BP: 130/70 mmHg TEMP: 38°C HR: 88b/mt RR: 18b/mt

Clinical Findings:

Diagnosis: URTI

Diagnosis Code:

Date of Onset : (dd/mm/yyyy)

Requested Investigations:

Estimated Cost:

Prescription:	Dose:	Duration:	Estimated Cost:
Amoxil			

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's Name: Dr. Sajid Sanaullah Khan, General Practitioner, DHA No: 05758224-001, PESHAWAR MEDICAL CENTER LLC, DUBAI, U.A.E.

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 : 17/6/2022