Administrative

MEDICAL CLAIM FORM

Claim Ref :J-661751/2022

Patient Name	:JOEL SHAILESH DSOUZA	**Service Date**	: 20-Jun-2022 **Network** : Green
Card No	:1017-029-116591800-01	**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	:08-Jul-1992		
Patient's Tel No	:971-52-1009439		

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

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☑ Acute ☐ Pre-existing and chronic ☐ Maternity

Chief Complaints: Chest pain Tenderness ↑ breathy

Duration: x 2 weeks

Vitals: BP: 130/80 mmHg TEMP: 36.4°C HR: 60 b/mt RR: 18 b/mt, SpO2 – 96% on RA

Clinical Findings:

Diagnosis: Chest PAIN SOB

Diagnosis Code:

Date of Onset : (dd/mm/yyyy)

Requested Investigations: CBC Electrolytes, BU Lipid profile ECG

Estimated Cost:

Prescription:	Dose:	Duration:	Estimated Cost:
Nopredon Duo gel			

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 *Stamp :*

Signature : *Date :*

DHA No: 05758224-001
PESHAWAR MEDICAL CENTER LLC
DUBAI - U.A.E.

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 :* 20-6-22