Print Date/ Time : 25-Jun-2022 12:29:55PM

Administrative

MEDICAL CLAIM FORM

Claim Ref :J-670329/2022

Patient Name	:MELANIE OPONDO SALAZAR	Service Date	: 25-Jun-2022
Card No	:I017-029-116125816-01	Health Provider	: Peshawar Medical Centre-Al Barsha
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	:Female		
Date Of Birth	:12-May-1993		
Patient's Tel No	:971-50-4586589		

Network : Green

Direct Access SP - YES

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:

Palpitations Cough
No Fever VOMITING 6-7 episodes
DIZZY x 3 DAYS No Leggs
Alcohol Rarely 1-2 Drinks

Duration:

x 3 DAYS

Vitals: BP: 123/76 mmHg TEMP: 37.1 °C HR: 90/m RR: 18/m Wt: 53 KG Ht 159 cm
SpO2 96%

Clinical Findings:

Mild Congestion

Diagnosis: URTI

Diagnosis Code:

Date of Onset : (dd/mm/yyyy)

Requested Investigations:

ECG CBC, Electrolytes Lipid Profile
TSH

Estimated Cost:

Prescription:	Dose:	Duration:	Estimated Cost:

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 *Stamp :*
General Practitioner
DHA No. 05758224-001
PESHAWAR MEDICAL CENTER LLC
DUBAI - U.A.E.

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 :* 25-06-22