Print Date/Time : 25-Jun-2022 6:27:36PM

Administrative

MEDICAL CLAIM FORM

Claim Ref :J-671411/2022

Patient Name	:HAMDY MESHRAF	Service Date	: 25-Jun-2022
Card No	:I017-029-116591797-01	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	:Male		
Date Of Birth	:13-Mar-1999		
Patient's Tel No	:971-54-7875413		

Network : Green

Direct Access SP - YES

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

23

☐ Acute ☐ Pre-existing and chronic ☐ Maternity

Chief Complaints: Auto immune Reaction Gen. RASH on back & chest MILD VITILIGO

Duration: 20 DAYS

Vitals: BP: 120/80 TEMP: 37°C HR: 60b/m RR: 20b/m

Clinical Findings: GEN. RASH DEPIGMENTATION BACK RASH CHEST

Diagnosis: VITILIGO

Diagnosis Code:

Date of Onset : (dd/mm/yyyy)

Requested Investigations: CBC electrolytes TSH, Glucose Lipid Profile

Estimated Cost:

Prescription:	Dose:	Duration:	Estimated Cost:
Clobetasol Cream			

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: Stamp :

Signature : Date :

Dr. Sajid Sanaullah Khan
General Practitioner
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 :* 25-06-22

For Clinic & Hospital Approval : **043811550** | For Pharmacy Approval : **043811560**