nextcare

ADMINISTRATIVE The member is allowed for **Out-Patient** at the **Peshawar Medical Centre**

Patient Name:	Pradeep Shivcharan	Gender:	Male	Validity Between:	02/Sep/2021and01/Sep/2022
Card No:	03FE8B0024BC1519	DOB:	20/Oct/1994	Coverage Information for:	Out-Patient
Pin #:		Identity Card	784-1994-5741025-8	Network:	OIC-OP @ PCP & Sp Referral @ RN
National ID:	784-1994-5741025-8	Service Date:	03-Jul-2022 12:46:36 PM	Radiology:	Covered
Regulator Member ID:	I008-002-116025844-02	Patient's Tel No:	971562370012		
Policy Holder:	THE CURRY LANE RESTAURANT (DHA-E)	Threshold Limit:			
Payer Name:	INS008 - Orient Insurance PJSC	Class:	B		
Category:	CAT A1	Out-Patient :			
Gatekeeper:	No	Patient's File No:		Pharmacy:	
		Consultation :	Co-Part: 20% Max(25 AED)	Laboratory:	Covered

Referral No:
Referred Service:

SUBJECTIVE ASSESSMENT

Symptom(s) as described by the patient (Chief Complaint): CP HTN Left ing Hernia / LH — Date of Symptoms/illness started: DD MM YYYY

Past Medical Surgical History? ☐ YES ☐ NO Family History Not Significant — Date of Symptoms/illness started: DD MM YYYY

Ciggs 1-2/DAY Alcohol - 1

Obs/Gyn Claims — Date of Symptoms/illness started: DD MM YYYY

Para: ☐	Gravida: ☐	AB: ☐	LMP:	Marital Status:	Marital Date:

OBJECTIVE ASSESSMENT

Clinical Findings: LIH

Vital Signs: B/P 130/90 T 37°c HR 68 RR 20

Assessment / Diagnosis: Hernia HTN — ☐ Acute ☐ Chronic ☐ Confirmed ☐ Suspected

Indicate diagnosis not symptom

1. Chest PAIN
2.

ACCIDENT/OCCUPATIONAL Claim Information (complete if claim is a result of accident or work related illness/injury)

Accident or illness due to work?	Injury due to road accident?	Describe how the accident or work related injury/illness occur:
☐ YES ☑ NO	☐ YES ☑ NO	
Date of accident or beginning of illness: DD MM YYYY		

MEDICAL PLAN Itemized Original Invoices and Applicable Prescriptions/Reports/Results must be enclosed to consider the claim

☐ Pharmacy:	Estimated Costs	☐ Laboratory / Radiology:	Estimated Costs
		CBC electrolytes CRP LIPID	

Is the following required	☐ Surgery:	☐ Endoscopy:	
	☐ Physiotherapy:	☐ Other Procedures:	
		If yes please specify	

Is In-patient Required? Length of stay _____ days | Indicate Provider: | Estimated Cost:

I hereby certify that all information mentioned are correct & that the medical services shown on this form were medically indicated & necessary for the management of this case.

I hereby authorize any Healthcare Provider, Insurer, Employer or other Organization to release any information regarding my medical condition and history to NEXtCARE for the purpose of determining insurance benefits. Medical management is the sole responsibility of doctor and the patient.

Dr. Sajid Sanaullah Khan
General Practitioner
DHA No: 0575822
PESHAWAR MEDICAL CENTER LLC

Treating Physician Name:			
Tel / Fax (important):	Date:		
Signature & Stamp	Patient's Signature (parent if minor)	Date:	03 07 22

Note: Claims must be submitted along with supporting documents within 30 days from date of service