Administrative

MEDICAL CLAIM FORM

Claim Ref :J-639698/2022

Patient Name	: MARY NGOIRI NJUGUNA	Service Date	: 09-Jun-2022	Network	: Green
Card No	: I017-029-116122275-01	Health Provider	: Peshawar Medical Centre-Al Barsha		Direct Access SP - YES
Policy Holder	: TH8 A HOUSE OF ORIGINALS HOTEL - 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	: 24-Mar-1991				
Patient's Tel No	: 971-58-1717461				

Co-Insurance:

CONSULT	LAB/RAD	PHYSIO	PHARMAC	IP	MATERN	DENTAL
10% max	NIL	NIL	NIL Max 1	NIL	10%	NA

☐ Acute ☐ Pre-existing and chronic ☐ Maternity

Chief Complaints:
Sore Throat x 1 DAY
DRY Cough
No fever No Travel No Sick Contacts

Duration:

Vitals: BP: 98/70 TEMP: 37.2 HR: Pulse 80 RR: Weight - 71.4

Clinical Findings:
Throat Congest Rest WNL

Diagnosis: URTI

Diagnosis Code:

Date of Onset : (dd/mm/yyyy)

Requested Investigations:
CBC electrolytes
TSH lipid panel

Estimated Cost:

Prescription:
Amoxicillin 500mg TID
Dextromethorphan 15ml TID

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: *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 :* 09-06-22