Print Date/ Time : 12-Jun-2022 12:2

Administrative

MEDICAL CLAIM FORM

Claim Ref :J-645049

Patient Name	: SHAHZADA MAKHDOOM ALI	Service Date	: 12-Jun-2022
Card No	: I017-029-117389852-01	Health Provider	: Peshawar Medical Centre-Al Barsha
Policy Holder	: IFA HI TRUNK FZE -	Doctor's Name	: SAJID RASHID(HNC MDC)
Payer Name	: ABU DHABI NATIONAL INSURANCE COMPANY	Co-Insurance	:
TPA	: E CARE INTERNATIONAL MEDICAL BILLING SERVICES	Remarks	:
Validity	: 01-Oct-2021 - To - 30-Sep-2022		
Gender	: Male		
Date Of Birth	: 18-May-1985		
Patient's Tel No	: 971-56-6442706		

Network : Green

Direct Access SP - YES

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

☐ Acute ☐ Pre-existing and chronic ☐ Maternity

Chief Complaints: Sore Throat · fever x 3 days
ECG Chest pain Cigg - 10-12 1/2 PPD 204
DM Not checked
Family History +ve for Heart

Duration:

Vitals: BP: 110/70 TEMP: 36.3 HR: 74 RR: 18/04

Clinical Findings: Exudates on Throat

Diagnosis: URTI Cough
CHEST PAIN
FEVER

Diagnosis Code:

Date of Onset : (dd/mm/

Requested Investigations: CBC Electrolytes TSH
Lipid Profile
ECG

Estimated Cost:

Prescription:	Dose:	Duration:	Estimated Cost:
- Augmentin 500 TID x 7 days - Mucinex			

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

Stamp :

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 : 12/06/202