Administrative

MEDICAL CLAIM FORM

Claim Ref :J-649262/20

Patient Name	:USMAN GHANI	Service Date	: 14-Jun-2022
Card No	:I014-029-113719031-03	Health Provider	: Peshawar Medical Centre-Al Barsha
Policy Holder	:STAYBRIDGE SUITES FC L.L.C-	Doctor's Name	: Sajid Sanaullah Khan
Payer Name	:RAK INSURANCE	Co-Insurance	:
TPA	:E CARE INTERNATIONAL MEDICAL BILLING SERVICES		
Validity	:03-Jan-2022 - To - 02-Jan-2023	Remarks	:
Gender	:Male		
Date Of Birth	:15-May-1989		
Patient's Tel No	:971-50-1503156		

Network : Blue

Direct Access SP - NO

CONSULT LAB/RAD	PHYSIO	PHARMAC IP	MATERN	DENTAL
20% max NIL	NIL	NIL Max 5 NIL	10%	NA

☐ Acute ☐ Pre-existing and chronic ☐ Maternity

Chief Complaints: VOMIT NAUSEA FEVER BURNING MICTURITION FREQUENCY Some Vomiting ↓ Urine ~~No~~ 1-2 CIGG/WEEK NO ALCOHOL

Duration:

Vitals: BP: 130/80 mmHg TEMP: 38°C HR: 88 b/mt RR: 18 b/mt.

Clinical Findings: weight - 67Kg, Height - 174Cm

Diagnosis: UTI

Diagnosis Code:

Date of Onset : (dd/mm/yyyy)

Requested Investigations:
- IV DNS
- Cyprocloxacin
- Inj PCT

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

Signature : Date :

Dr. Sajid Sanaullah Khan
General Practitioner
DHA No: 5075[illegible]-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: 14/6/2022