AL MADALLAH Form

almadallah Healthcare Management

Claim Form

استمـــارة المطالبة

Please complete all the fields

For Pre Approval kindly call our Help Line for 24 hours: 04 559 1322 Fax: +9714 434 2310

No:

Date:	30-May-2024	Healthcare Provider:	Irham Medical Center Arjan				
PATIENT INFORMATION							
Patient's Name (as on card)	LUZ BELTRAN		○ Mr. ○ Mrs. ○ Ms.				
Card #	Policy No.		Birth Date :	25-May-1976 dd mm yy	Sex:	Female	
1689197							
INFORMATION			*To be completed by Physician*				
Date of present symptoms:	30/05/2024 dd mm yy	Symptom(s) as described by Patient:					

Complaint

PC: Dizziness, headache, nasal congestion, nasal discharge,

Duration/Onset: 26/05/2024

History of presenting complaint: Dizziness is said to occurr when she rises from a bending position with associated headache. Also has associated body pains and occasional weakness, but there is no fever, no cough and has no GIT symptoms and no urinary symptoms.

Past medical history: Known hypertensive but no longer on medication as she claimed her BP has been normal for the past 7months. She is not diabetic.

Family history: not significant

Social history: Does not smoke and does not take alcohol.

General exam: satisfactory

CVS: Pulse = 86bpm, regular, normal volume. BP left arm (sitting) = 123/88mmhg, standing = 137/98mmhg, Right arm (sitting) = 127/84mmhg, standing = 133/95mmhg.

Assessment: ??vertigo, ??othostatic hypotension (not likely as there is no significant difference in sitting and standing BP), ??anemia, ??upper respiratory tract infection.

Pre-existing Condition(s) being treated for :	○ No	○ Yes	If Yes Specify	
Chronic Medications:	○ No	○ Yes		
Family History of any Illness	○ No	○ Yes		

OBJECTIVE/ASSESSMENT — *To be completed by Physician*

Clinical Finding

Date	CPT Code	Treatment	Qty	Unit Price
30-May-2024	9	Consultation GP **(General Consultation)**	1	**30.00**
30-May-2024	85652	Sedimentation rate, erythrocyte; automated **(Lab)**	1	**5.40**
30-May-2024	81001	Urinalysis, by dip stick or tablet reagent for bil **(Lab)**	1	**6.30**
30-May-2024	86140	C-reactive protein; **(Lab)**	1	**12.60**
30-May-2024	85025	Blood count; complete (CBC), automated (Hgb, Hct, **(Lab)**	1	**15.30**
				69.60

Cause	☐ Physical Illness	☐ Accident	☐ Maternity	☐ Preventive	☐ Psychiatric	☐ Dental	☐ Work Related
☐ Other(s) Explain							
Assessment/ Diagnosis				☐ Acute	☐ Chronic	☐ Confirmed	☐ Suspected

Type	Date	Doctor	ICD Code	Diagnosis	Notes	year	Problem Role
Primary	30-May-2024	Enomen Goodluck	J06.9	Acute upper respiratory infection, unspecified			Admitting Provider
Secondary	30-May-2024	Enomen Goodluck	R42	Dizziness and giddiness			Admitting Provider
Secondary	30-May-2024	Enomen Goodluck	H81.10	Benign paroxysmal vertigo, unspecified ear			Admitting Provider
Secondary	30-May-2024	Enomen Goodluck	I95.1	Orthostatic hypotension			Admitting Provider
Secondary	30-May-2024	Enomen Goodluck	N39.0	Urinary tract infection, site not specified			Admitting Provider

MEDICAL PLAN

Itemized Original Invoices & Applicable Prescriptions/Reports/Results must be enclosed to consider the claim

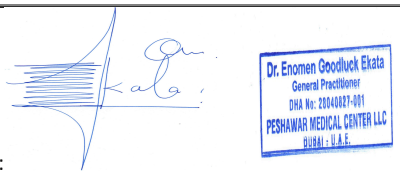
☐ **Consultation**	☐ **Physiotherapy**	☐ **Laboratory**	☐ **Radiology/Other**	☐ **Pharmacy**
			For Almadallah's Use only	
Pre-authorization Required for:			As per agreed tariff	
Full details of proposed treatment/Surgery/Medicine:			Approval Code:	

IN-PATIENT

Discharge summary, Itemized Invoices, Report, Results should be attached

Length of stay:	**Provider: AL MADALLAH RN4**	**Cost:**

The above information is true to the best of my knowledge. I hereby authorize any Healthcare Provider, Insurer, Employer or other Organization to release any information regarding my medical conditions & history to **ALMADALLAH** for the purpose of determining insurance benefits

Treating Physician Name: Enomen Goodluck		**Patient/Guardian signature**	
Tel/Fax: 1234567			
Signature & Stamp: 			
Date: 30-05-2024		Date: 30-05-2024	

Claims should be submitted with supporting documents within 30 days from date of service or as per contract.