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:	10-Jun-2024	Healthcare Provider:	Irham Medical Center Arjan				
PATIENT INFORMATION							
Patient's Name (as on card)	MUHAMMAD ADNAN FAZAL REHMAN	○ Mr. ○ Mrs. ○ Ms.					
Card #	Policy No.	Birth Date :	01-Jan-1988	Sex:	Male		
1659484	IM237EA NLSB		dd mm yy				
INFORMATION		*To be completed by Physician*					
Date of present symptoms:	10/06/2024 dd mm yy	Symptom(s) as described by Patient:					
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
10-Jun-2024	9.01	Follow Up - Consultation GP **(General Consultation)**	1	**0.00**
10-Jun-2024	96375	Therapeutic, prophylactic, or diagnostic injection **(Co.Pay)**	2	**10.80**
10-Jun-2024	2190-106618-1001	PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) S **(Pharmacy)**	1	**8.40**
10-Jun-2024	0195-107704-0801	CEFTRIAXONE-TABUK IV-(CEFTRIAXONE : 1 G) POWDER F **(Pharmacy)**	1	**48.50**
10-Jun-2024	0125-122107-1022	DEXAMETHASONE SODIUM PHOSPHATE-(DEXAMETHASONE : 4 **(Pharmacy)**	1	**2.34**
10-Jun-2024	0005-149902-1021	CLOFEN -(DICLOFENAC SODIUM : 75 MG/3ML) SOLUTION **(Pharmacy)**	1	**6.50**
10-Jun-2024	96365	Intravenous infusion, for therapy, prophylaxis, or **(Co.Pay)**	1	**46.80**
10-Jun-2024	96372	Therapeutic, prophylactic, or diagnostic injection **(Co.Pay)**	1	**9.00**
				132.34

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	10-Jun-2024	Enomen Goodluck	J06.9	Acute upper respiratory infection, unspecified			Admitting Provider
Secondary	10-Jun-2024	Enomen Goodluck	R50.9	Fever, unspecified			Admitting Provider
Secondary	10-Jun-2024	Enomen Goodluck	R05	Cough			Admitting Provider

MEDICAL PLAN

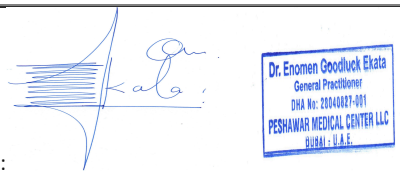
Itemized Original Invoices & Applicable Prescriptions/Reports/Results must be enclosed to consider the claim

☐ 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: 10-06-2024	Date: 10-06-2024		
Claims should be submitted with supporting documents within 30 days from date of service or as per contract.			