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:	27-Oct-2023	**Healthcare Provider:**	Irham Medical Center Arjan				
PATIENT INFORMATION							
Patient's Name (as on card)	AKMAL HUSSAIN FAROOK FAROOK	○ Mr. ○ Mrs. ○ Ms.					
Card #	Policy No.	Birth Date :	23-Sep-1989 *dd mm yy*	**Sex:**	Male		
1659505							
INFORMATION		***To be completed by Physician***					
Date of present symptoms:	27/10/2023 *dd mm yy*	Symptom(s) as described by Patient:					

Complaint

The patient has hypothyroidism since three months and TSH is high came for follow up using one tablet 0.1mg levothyroxine since 20/7/2023

has also severe gastritis since three months on 20/7/2023

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						
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	27-Oct-2023	Sajid Sanaullah	E03.9	Hypothyroidism, unspecified			Admitting Provider
Secondary	27-Oct-2023	Sajid Sanaullah	K29.00	Acute gastritis without bleeding			Admitting Provider
Secondary	27-Oct-2023	Sajid Sanaullah	M62.81	Muscle weakness (generalized)			Admitting Provider
Secondary	27-Oct-2023	Sajid Sanaullah	R53.82	Chronic fatigue, unspecified			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:	

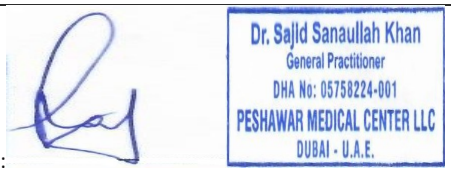
IN-PATIENT

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

Length of stay:	**Provider: ALMadallah GN+ GN RN GOVT POLICE DEWA**	**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: Sajid Sanaullah		**Patient/Guardian signature**	
Tel/Fax: 0501234567			

Signature & Stamp: 	
Date: 27-10-2023	Date: 27-10-2023
Claims should be submitted with supporting documents within 30 days from date of service or as per contract.	