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:	02-Nov-2023	**Healthcare Provider:**	Irham Medical Center Arjan				
PATIENT INFORMATION							
Patient's Name (as on card)	CHETNA SHARMA		○ Mr. ○ Mrs. ○ Ms.				
Card #	Policy No.		Birth Date :	16-Dec-1988 dd mm yy	**Sex:**	Female	
1666952							
INFORMATION			***To be completed by Physician***				
Date of present symptoms:	02/11/2023 dd mm yy	Symptom(s) as described by Patient:					

Complaint

severe headache in left side of head since three weeks ago started 10/10/2023

the headache is severe and in one side of the head

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**

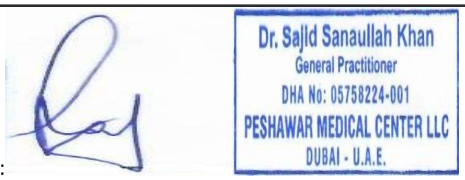
Type	Date	Doctor	ICD Code	Diagnosis	Notes	year	Problem Role
Primary	02-Nov-2023	Sajid Sanaullah	G43.809	Other migraine, not intractable, without status migrainosus			Admitting Provider
Secondary	02-Nov-2023	Sajid Sanaullah	R51.9	Headache, unspecified			Admitting Provider
Secondary	02-Nov-2023	Sajid Sanaullah	M62.838	Other muscle spasm			Admitting Provider
Secondary	02-Nov-2023	Sajid Sanaullah	D64.9	Anemia, 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: 02-11-2023	Date: 02-11-2023		
Claims should be submitted with supporting documents within 30 days from date of service or as per contract.			