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:	04-Nov-2023	**Healthcare Provider:**	Irham Medical Center Arjan				
PATIENT INFORMATION							
Patient's Name (as on card)	OMAR AHMED MAHMOUD ALI	○ Mr. ○ Mrs. ○ Ms.					
Card #	Policy No.	Birth Date :	18-Nov-1981 *dd mm yy*	**Sex:**	Male		
1659530	IM233EA						
INFORMATION		***To be completed by Physician***					
Date of present symptoms:	04/11/2023 *dd mm yy*	Symptom(s) as described by Patient:					

Complaint
FUC of Burn on the right hand.

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	04-Nov-2023	Sajid Sanaullah	L08.9	Local infection of the skin and subcutaneous tissue, unsp			Admitting Provider
Secondary	04-Nov-2023	Sajid Sanaullah	A49.9	Bacterial infection, unspecified			Admitting Provider
Secondary	04-Nov-2023	Sajid Sanaullah	T23.101S	Burn of first degree of right hand, unsp site, sequela			Admitting Provider

MEDICAL PLAN

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

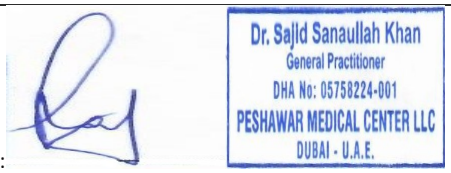
☐ **Consultation**	☐ **Physiotherapy**	☐ **Laboratory**	☐ **Radiology/Other**	☐ **Pharmacy**
			For Almadallah's Use only	
Pre-authorization Required for:			As per agreed tariff	
Full details of proposed treatment/Surgery/Medicine:			Approval Code:	

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: Sajid Sanaullah		**Patient/Guardian signature**	
Tel/Fax: 0501234567			

Signature & Stamp: 	
Date: 04-11-2023	Date: 04-11-2023
Claims should be submitted with supporting documents within 30 days from date of service or as per contract.	