AL MADALLAH Form

almadallah Healthcare Management

Claim Form

استمـــارة المطالبة

No:

Please complete all the fields

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

Date:	27-Nov-2023	**Healthcare Provider:**	Irham Medical Center Arjan			
PATIENT INFORMATION						
Patient's Name (as on card)	DULASHANI SEWWANDI RANATHUNGA GODAGAMA VIDANALAGE	○ Mr. ○ Mrs. ○ Ms.				
Card #	Policy No.	Birth Date :	05-Jan-1998 *dd mm yy*	**Sex:**	Female	
1609868	IF375EC					
INFORMATION		***To be completed by Physician***				
Date of present symptoms:	27/11/2023 *dd mm yy*	Symptom(s) as described by Patient:				

Complaint

C/o: Upper abdominal pain that is burning in character and radiates to the back.

Associated vomiting for which she has had over 10episodes in the last one hour

Has associated high grade fever.

Was previously managed for a febrile illness last week in another facility.

Not hypertensive and not diabetic.

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-Nov-2023	Enomen Goodluck	K29.00	Acute gastritis without bleeding			Admitting Provider
Secondary	27-Nov-2023	Enomen Goodluck	K52.1	Toxic gastroenteritis and colitis			Admitting Provider
Secondary	27-Nov-2023	Enomen Goodluck	E86.0	Dehydration			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 RN3**	**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: Dr. Enomen Goodluck Ekata General Practitioner DHA No: 23040827-001 PESHAWAR MEDICAL CENTER LLC DUBAI - U.A.E.			
Date: 27-11-2023		Date: 27-11-2023	
Claims should be submitted with supporting documents within 30 days from date of service or as per contract.			