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:	25-Dec-2023	Healthcare Provider:	Irham Medical Center Arjan

PATIENT INFORMATION

Patient's Name (as on card)	CHRISTO JOSEPH GEORGE	○ Mr. ○ Mrs. ○ Ms.			
Card #	Policy No.	Birth Date :	31-Oct-1993 (dd mm yy)	Sex:	Male
1688661					

INFORMATION

To be completed by Physician

Date of present symptoms:	25/12/2023 (dd mm yy)	Symptom(s) as described by Patient:

Complaint
pain in nasopharynx
dry and wet cough
FEVER WITH CHILLS
weakness after viral infection

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	25-Dec-2023	Sajid Sanaullah	R50.9	Fever, unspecified			Admitting Provider
Secondary	25-Dec-2023	Sajid Sanaullah	R53.1	Weakness			Admitting Provider
Secondary	25-Dec-2023	Sajid Sanaullah	R05	Cough			Admitting Provider
Secondary	25-Dec-2023	Sajid Sanaullah	R07.0	Pain in throat			Admitting Provider
Secondary	25-Dec-2023	Sajid Sanaullah	J30.9	Allergic rhinitis, unspecified			Admitting Provider

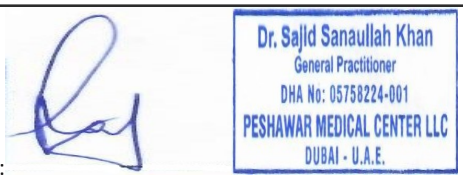
MEDICAL PLAN

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: 25-12-2023	Date: 25-12-2023	
Claims should be submitted with supporting documents within 30 days from date of service or as per contract.		