



Claim Form

استمارة 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-Dec-2023	Healthcare Provider:	Irham Medical Center Arjan				
PATIENT INFORMATION							
Patient's Name (as on card)	ARNOLD DE GUZMAN GONZALES			☐ Mr. ☐ Mrs. ☐ Ms.			
Card #	Policy No.	Birth Date :	22-Nov-1972	Sex:	Male		
1451911	PM120E3		dd mm yy				
INFORMATION							
To be completed by Physician							
Date of present symptoms:	27/12/2023	Symptom(s) as described by Patient:					
	dd mm yy						
Complaint							
C/o: Diarrhea, Vomiting, abdominal pain. Associated mucus in stool but no blood. Also fever Hypertensive and diabetic. Abd: Scaphoid, marked epigastric tenderness							
Pre-existing Condition(s) being treated for :		☐ No	☐ Yes				
Chronic Medications:		☐ No	☐ Yes	If Yes Specify			
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-Dec-2023	Enomen Goodluck	K29.00	Acute gastritis without bleeding			Admitting Provider
Secondary	27-Dec-2023	Enomen Goodluck	A09	Infectious gastroenteritis and colitis, unspecified			Admitting Provider
Secondary	27-Dec-2023	Enomen Goodluck	E11.65	Type 2 diabetes mellitus with hyperglycemia			Admitting Provider
Secondary	27-Dec-2023	Enomen Goodluck	I10	Essential (primary) hypertension			Admitting Provider
Secondary	27-Dec-2023	Enomen Goodluck	I20.9	Angina pectoris, unspecified			Admitting Provider
Secondary	27-Dec-2023	Enomen Goodluck	K21.00	Gastro-esophageal reflux dis with esophagitis, without bleed			Admitting Provider

Type	Date	Doctor	ICD Code	Diagnosis	Notes	year	Problem Role
Secondary	27-Dec-2023	Enomen Goodluck	Z79.899	Other long term (current) drug therapy			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

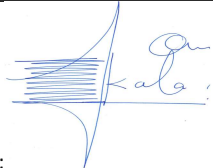
Discharge summary, Itemized Invoices, Report, Results should be attached

Length of stay:	Provider: AL MADALLAH RN3	Cost:
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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	
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Tel/Fax: 1234567	
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Signature & Stamp:

Date: 27-12-2023	Date: 27-12-2023
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Claims should be submitted with supporting documents within 30 days from date of service or as per contract.