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:** | 13-Apr-2024 | **Healthcare Provider:** | Irham Medical Center Arjan | | | | |
| **PATIENT INFORMATION** | | | | | | | |
| **Patient's Name (as on card)** | Khulood Mahmood | | ○ Mr. ○ Mrs. ○ Ms. | | | | |
| Card # | Policy No. | | Birth Date : | 22-Aug-1990 *dd mm yy* | **Sex:** | Female | |
| 784-1990-5937491-0 | | | | | | | |
| **INFORMATION** | | | ***To be completed by Physician*** | | | | |
| Date of present symptoms: | 13/04/2024 *dd mm yy* | Symptom(s) as described by Patient: | | | | | |

**Complaint**

C/o: Recurrent headaches, pain in throat and fever.

Also coughing which is dry,

Symptom onset since one week (05/04/2024).

There is no chest pain but has occasional difficulty breathing.

| | | | | |
|---|---|---|---|---|
| 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

| Date | CPT Code | Treatment | Qty | Unit Price |
|---|---|---|---|---|
| 13-Apr-2024 | 9 | Consultation Gp (General Consultation) | 1 | 60.00 |
| | | | | 60.00 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| **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 | 13-Apr-2024 | Enomen Goodluck | J02.9 | Acute pharyngitis, unspecified | | | Admitting Provider |
| Secondary | 13-Apr-2024 | Enomen Goodluck | J03.90 | Acute tonsillitis, unspecified | | | Admitting Provider |
| Secondary | 13-Apr-2024 | Enomen Goodluck | R05 | Cough | | | Admitting Provider |
| Secondary | 13-Apr-2024 | Enomen Goodluck | G43.101 | Migraine with aura, not intractable, with status migrainosus | | | Admitting Provider |
| Secondary | 13-Apr-2024 | Enomen Goodluck | R51.9 | Headache, unspecified | | | Admitting Provider |

## MEDICAL PLAN

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

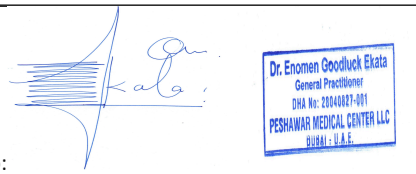
| | | | | |
|---|---|---|---|---|
| ☐ **Consultation** | ☐ **Physiotherapy** | ☐ **Laboratory** | ☐ **Radiology/Other** | ☐ **Pharmacy** |
| | | | For Almadallah's Use only | |
| Pre-authorization Required for: | | | As per agreed tariff | |
| Full details of proposed treatment/Surgery/Medicine: | | | 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: Enomen Goodluck** | | **Patient/Guardian signature** | |
| **Tel/Fax:** 1234567 | | | |
| Signature & Stamp:   | | | |
| Date: 13-04-2024 | Date: 13-04-2024 | | |
| Claims should be submitted with supporting documents within 30 days from date of service or as per contract. | | | |