AL MADALLAH Form





No:	
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Please complete all the fields
For Pre Approval kindly call our Help Line for 24 hours: 04 559 1322 Fax: +9714 434 2310

Date: 09-Dec-2023 Healthcare Provider:				Irham Medical Center Arjan				
PATIE	NT INFORMATION	İ		,				
Patient	's Name (as on card)	MOHAMMAD AKBAR MAZHAR KHAN		○Mr. ○Mrs. ○Ms.				
Card #		Policy No.		Birth Date :	20-Jun- 1982	Sex:	Male	
16443	26	IM250EEBP LSB		dd mm yy	J			
INFO	RMATION)2		To be completed by Physician				
Date of present symptoms: O9/12/2023 dd mm yy Symptom(s) as described by Patient:								
Comp	plaint							
he ha	s been thorax pain at w	ork one hour ago at 10 Am						
Dro ovi	sting Condition(s) boing	troated for	○No	○Yes				
Pre-existing Condition(s) being treated for : Chronic Medications:			○No	○Yes	If Yes			
Family	History of any Illness		○No	○Yes	Specify			
OBJECT	IVE/ASSESSMENT			To be completed by Ph	ysician			
Clinical	Finding							
Cause	☐ Physical Illness	Accident	☐ Maternity	☐ Preventive	Sychiatric	☐ Dental	☐ Work Related	
Other(s) Explain								
Assessr	ment/ Diagnosis			☐ Acute	☐ Chronic	Confirmed	Suspected	

Primary 09-Dec-2023 Sajid Sanaullah K27.3 Acute peptic ulcer, site unsp, w/o hemorrhage or perforation Provider Secondary 09-Dec-2023 Sajid Sanaullah I51.9 Heart disease, 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: N-PATIENT					Chinesort						
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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 re any information regarding my medical conditions & history to ALMADALLAH for the purpose of determining insurance benefits Treating Physician Name: Sajid Sanaullah Tel/Fax: 0501234567 Dr. Sajid Sanaullah Khan Gereri Pactitony PSMAWA MEDICAL CENTER LC DUBAI-ULE: Date: 09-12-2023 Date: 09-12-2023	Primary	09-Dec-2023	Sajid Sanaullah	K27.3							
Consultation	Secondary	09-Dec-2023	Sajid Sanaullah	151.9	Heart disease, unspecified						
Pre-authorization Required for: As per agreed tariff Approval Code: IN-PATIENT			es & Applicable	Prescrip	tions/Reports,	/Results must be	enclosed to	conside	er the	claim	
Pre-authorization Required for: As per agreed tariff Approval Code: IN-PATIENT			_	<u> </u>	<u> </u>				T		
Full details of proposed treatment/Surgery/Medicine: Approval Code:				1							
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Date: 09-12-2023 Date: 09-12-2023	Signature & S	tamp:	Gen DHA N PESHAWAR	neral Practitioner No: 05758224-001 MEDICAL CENTE							
						Date: 09-12-2023					
Claims should be submitted with supporting documents within 30 days from date of service or as per contract.			th supporting docume	ents withir	30 days from date		contract.				