

AL MADALLAH Form



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:	09-Dec-2023	Healthcare Provider:	Irham Medical Center Arjan			
PATIENT INFORMATION						
Patient's Name (as on card)	MOHAMMAD AKBAR MAZHAR KHAN		☐ Mr. ☐ Mrs. ☐ Ms.			
Card #	Policy No.	Birth Date :	20-Jun-1982	Sex:	Male	
1644326	IM250EEBP LSB		dd mm yy			
INFORMATION			<i>To be completed by Physician</i>			
Date of present symptoms:	09/12/2023	Symptom(s) as described by Patient:				
	dd mm yy					
Complaint						
he has been thorax pain at work one hour ago at 10 Am						
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			<i>To be completed by Physician</i>			
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	09-Dec-2023	Sajid Sanaullah	K27.3	Acute peptic ulcer, site unsp, w/o hemorrhage or perforation			Admitting 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:		

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 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	
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Tel/Fax: 0501234567	
 	
Signature & Stamp:	
Date: 09-12-2023	Date: 09-12-2023
Claims should be submitted with supporting documents within 30 days from date of service or as per contract.	