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:	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			***To be completed by Physician***				
Date of present symptoms:	09/12/2023 *dd mm yy*	Symptom(s) as described by Patient:					
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
Secondary	09-Dec-2023	dr hossein karim	K27.3	Acute peptic ulcer, site unsp, w/o hemorrhage or perforation			Admitting Provider

Type	Date	Doctor	ICD Code	Diagnosis	Notes	year	Problem Role
Primary	09-Dec-2023	dr hossein karim	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: dr hossein karim		**Patient/Guardian signature**	
Tel/Fax:			
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.