AL MADALLAH Form

almadallah Healthcare Management

Claim Form

استمـــارة 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:	16-Jan-2024	**Healthcare Provider:**	Irham Medical Center Arjan

PATIENT INFORMATION

Patient's Name (as on card)	AFAJAL KHAN SHAH MOHAMMAD	○ Mr. ○ Mrs. ○ Ms.			
Card #	Policy No.	Birth Date :	20-Apr-1997 *dd mm yy*	**Sex:**	Male
1538146	IM905EB				

INFORMATION

To be completed by Physician

Date of present symptoms:	16/01/2024 *dd mm yy*	Symptom(s) as described by Patient:

Complaint

C/o: Fever, cough, pain in throat, upper abdominal pain that radiates to the back.

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
Primary	16-Jan-2024	Enomen Goodluck	K29.00	Acute gastritis without bleeding			Admitting Provider
Secondary	16-Jan-2024	Enomen Goodluck	J02.8	Acute pharyngitis due to other specified organisms			Admitting Provider
Secondary	16-Jan-2024	Enomen Goodluck	J06.0	Acute laryngopharyngitis			Admitting Provider
Secondary	16-Jan-2024	Enomen Goodluck	R50.81	Fever presenting with conditions classified elsewhere			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: Enomen Goodluck		**Patient/Guardian signature**	
Tel/Fax: 1234567			
Signature & Stamp: Dr. Enomen Goodluck Ekata General Practitioner DHA No: 23040827-001 PESHAWAR MEDICAL CENTER LLC DUBAI : U.A.E.			
Date: 16-01-2024	Date: 16-01-2024		
Claims should be submitted with supporting documents within 30 days from date of service or as per contract.			