Claim Form

استمـارة المطالبت

Please complete all the fields

For Pre Approval kindly call our help Line for 24 Hours: 04 434 2322 Fax: +9714 434 2310

Date: 29-November-2024	Healthcare Provider:

PATIENT INFORMATION

Patient's Name (as on card): jishith ks			Mr. ☐ Mrs. ☐ Ms. ☐
Card # 56342374652	Policy No.	Birth Date: 08-December-1999	Sex: M

INFORMATION

Date of present symptoms:	Symptom(s) as described by Patient:

Pre-existing Condition(s) being treated for:	No ☐	Yes ☐	If Yes
Chronic Medications:	No ☐	Yes ☐	Spe
Family History of any Illness:	No ☐	Yes ☐	cify:

OBJECTIVE/ASSESSMENT

Clinical Findings:-

Cause ☐ Physical Illness	☐ Accident	☐ maternity	☐ Preventive	☐ Psychiatric	☐ Dental	☐ Work Related

☐ Other(s),Explain

Assessment/Diagnosis	☐ Acute	☐ Chronic	☐ Confirmed	☐ Suspected

Rash and other nonspecific skin eruption

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: CONSULTATION, DENTAL, DRUG, GENERAL PROCEDURES, LAB	Asper agreed tariff:
Full details of proposed treatment/Surgery/Medicine Consultation GP COMPLETE CBC W/AUTO DIFF WBC OLFEN	Approval Code:

IN-PATIENT

Discharge summary, Itemized Invoices, Report, Results should be attached

Length	Provider:	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: RAJASEKHAR	**Patient/Guardian signature**
Tel./Fax: 04 337 9040/null	
Signature&Stamp	
Date: 29-November-2024	Date: 29-November-2024

Claims should be submitted with supporting documents with in 30 days from date of service or as percontract