ALMADALLAH PROVIDER'S MANUAL

Version 3, February 2012

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SECTION ONE

ALMADALLAH MEMBER HEALTH CARD

Front and Back of Card:

Group Logo

Logo

almadallah
Healthcare Management

Member's Card

Card No.

Name :

National ID No.:

Network:

Deductible:

Optical: Dental:

Policy Code:

D. O. B. :

Category:

Expiry Date:

Co-Participation:

Maternity:

Note: Pre-approval required for : Dental, Maternity, Optical and Inpatient, except for A-VIP Category.

Healthcare Provider Network: GN +, GN

Deductible: Amount to be collected from the Patient for consultation

Policy Code: For Almadallah internal use

Member Category: as indicated

Expiry Date: as indicated

Co-Participation: Amount to be collected from Patient as per policy

Pre-approval: For more details refer to Appendix J

www.almadallah.ae

For 24 hours assistant please contact : 04 4342322

للمساعدة على مدار ٢٤ ساعة يرجى الاتصال على الرقم: ٠٤ ٤٣٤٢٣٢٢

HOSPITALS AND CLINICS

A. RECEPTION / FRONT DESK STAFF RESPONSIBILITY

1. **Emergency:** Top priority situation where urgent assistance is required and presence of specialist is important to recover the patient condition. After attending to the patient and stabilizing the condition: -take Verbal Approval from Almadallah Call Center at telephone: **04-4342322.** For Admission and Medical Management the Claim Form will be provided and stamped and signed by the Pre-approval doctor within **24 hours** and Call Center Office will fax/email the Verbal Pre-approval Form. If further information is required by the Almadallah Call Center for claim evaluation, kindly fax relevant documents ie. Medical reports and test results to justify the services and extension for patient stay.

2. **Non-emergency:** After receiving the patient, Almadallah card must be verified for its validity and category and for any specific indications/conditions. For elective surgery, kindly fax medical report and cost estimate to the Claims Center for claim approval or call the Call Centre for verbal approval.

3. **Companion:** Reference to coverage indications in Appendix J.

Please verify the member's Almadallah card with other valid personal ID for Almadallah's members visiting your facility.
For parents of the member or minors/children of the member, please verify with their personal ID or with the members ID.

1. **Expiry Date:** The date that the insured member's policy benefits and ability to receive direct billing service at your facility is terminated.
   Cards for some self-funded schemes do not have an expiry date
   Those cards are valid for unlimited period unless advised otherwise

   Cards with expiration dates
   The expiry date is inclusive of the end date.
   For example: Expiry Date = 31-Dec- 2010.
   - A consultation occurring on December 31, 2010 is inclusive up to 12 midnight. For chronic medication, when the prescribed period is beyond the expiration date, Almadallah must be billed until the expiry date only. The rest of the medicine has to be billed to the member directly.
   - Claims received by Almadallah relating to expired cards will not be paid and will be the provider's responsibility.

2. **Coverage:** Our members will have different coverage guidelines according to the category designation (any changes to the coverage shall be endorsed to all providers within two weeks in advance):
   Reference to the list of Categories in Appendix J.

3. **VIP cards:** Cards with A-VIP or A-V category denote that the card holder is a very important person and should be attended to immediately and with special assistance. **Reference to Pre-approval policy in** **Appendix J.**

4. **Policy Code**: Is utilized for Almadallah's internal use for classification of the insured company.

B. ADMINISTRATIVE/TREATING PHYSICIAN/NURSE RESPONSIBILITY

The Administrative section**,** Objective / Assessment, and Medical Plan sections of Almadallah Claim Form (Appendix A) should be completed in detail by administrator, treating physician and nurse respectively.

1. All fields are mandatory. Refer to Checklist Form (Appendix K)

2. Handwriting must be **CLEAR** and **LEGIBLE** (Claims that are unreadable shall be returned back to the Provider).

3. Please ensure that the card number is indicated **CORRECTLY** on the Claim Form. Attach a photocopy of the Health Card with the Claim Form.

4. Stamp from treating physician is required.

5. Please adhere to the billing, submission and re-submission time periods as per contract.

6. Please ensure that the date on the Claim Form and the Pre-approval Form are the same.

7. Reasons for claim denial or partially paid claims will be clearly stated in the Reconciliation Report upon cheque issuance. CD with scanned claims will be couriered to the provider.
   Almadallah is in the process of constructing electronic updates of claims services to be available to Providers under secure access.

8. Ensure that the Patient (or relative for minors) sign the Claim Form.

9. Check if the medical diagnosis/procedures/services are excluded or require Pre-approval. Refer to Exclusions List, Pre-approval Indications and Appendix J.

   Pre-approvals are required for all outpatient services related to Maternity, and Optical benefits and as indicated for Physiotherapy services. **Refer to Appendix J.**
   For Category A VIP or AV, Pre-approval is required for all Dental Services ONLY.

10. **Pharmacy Prescription**: The ***original*** prescription (if prescribed) should be handed to the patient along with a carbon copy of the Claim Form –*both* stamped and signed by the treating physician.

11. **Diagnostic Test Prescription**: The laboratory/radiology order (if any) should be handed to the patient along with a stamped copy of the Claim Form.

12. For diagnostic procedures that are to be conducted outside the hospital/clinic and fall under the Pre-approval indications, it is the hospital/clinic responsibility to obtain the Pre-approval from Almadallah. The name of the Diagnostic Center you are referring to should be mentioned on the Claim Form and should be in the Almadallah Network corresponding to the member's category.

13. All Pathology and Radiology Reports must be signed by a licensed Pathologist or Radiologist respectively in order to be valid and acknowledged with the submitted Claim.

14. 50% discount to be applied on the 2nd Surgical Procedure performed at the same sitting.

15. **Pre-approvals for Diagnostic and Pharmacy:** For members to be sent to Diagnostic Center and/or Pharmacy, please provide them with a copy of the written approval and a copy of Pre-approval Form (for a service that requires pre-approval) along with a stamped copy of the Claim Form.

16. Medications that are not medically necessary, not medically appropriate, not related to diagnosis and medications not prescribed by the treating physician will not be covered.

17. For knee replacement claims, please include CD copy for Arthroscopies and scanned digital pre-operative and post-operative X-ray films.

18. ECG service will be paid only if submitted with graphic recording/typed report (stamped by the physician) or both.

19. EEG service will be paid only if submitted with graphic recording/typed report (stamped by the physician) or both.

20. Tympanometry will be paid only if submitted with graphic recording/both graph and typed report.

21. Audiometry will be paid only if submitted with graphic recording/both graph and typed report.

C. FINANCIAL RESPONSIBILITY

1. For cases that are not authorized or excluded, 100% of all related charges should be collected from the patient after applying the agreed upon network discount.

2. For eligible/authorized cases, any applicable Deductible Fee/Co-participation Fee/amount exceeding sublimit must be collected from the patient and the eligible remainder should be billed to Almadallah.

3. **The Deductible Fee** is a fixed amount paid (Reference to Deductible Fee indications and amount in Appendix J.) by the patient on the Consultation prior to leaving the clinic and will be indicated as AED 20, AED 50, etc. Almadallah will not be held responsible in case of failure to collect Deductible Fee from patients. **T**he Government Hospitals (DHA) Deductible Fee is 20AED on Consultation and 50AED is the Deductible Fee for Consultations at other Network Providers. ***The Deductible Fee amount must then be deducted from total Consultation charge to Almadallah.***
   In Optical Claims, Vision Test is considered as Consultation and the Deductible fee shall be collected from the member and deducted from the total Invoice.

4. Please be informed that the Deductible Fee amount is applicable on the Consultation fee portion of the claim only. In the event the Deductible Fee is higher than the Consultation Fee, the Deductible Fee collected should be equal to the Consultation Fee. For example: Deductible Fee = AED 100, however the Consultation charged by your clinic is AED 75. Please collect only AED 75 from the patient. If, mentioned on the card Deductible: Nil, it means that Deductible Fee is zero. In this case, the Consultation Fee shall be billed to Almadallah in full.

5. **Co –participation Fee, when applicable,** is a percentage paid on Net Price of all services (Reference to Co-participation Fee indications and amounts in Appendix J.) and Almadallah will not be held responsible in case of failure to collect Co-participation from the patient. When applicable to member policy, Co-participation is applicable on each and every service and should be collected after the discount has been applied and the deductible collected. Some cards specify special conditions regarding Co-participation. Example: 20% on pharmacy. In such cases, follow the instructions written on the card and collect the Co-participation amount against the specified services only. Applying Co-participation policy is monitored by Almadallah.

6. Almadallah is only responsible for paying those coverable services as listed on the agreed tariff list and covered per the Provider's Manual. Please list the rendered individual service tariffs on the Invoice Form as they are stated in the Agreement Tariff List, noting the Gross Price, Discount percentage, Net Price and when applicable Co-participation Fee and Deductible Fee due from member.

7. For the coverable billed services that are not available on the tariff list, a waiting period of 3 working days will be given to the Provider to respond to price negotiations prior to Technical Denial of the Claim Form being issued by Almadallah. Please refer to Contract Page #5 under ***inclusive contractual rates*** for the procedure of accepting any newly added service and forward an email to network@almadallah.ae with formal request in order to avoid future Claim Rejections.

8. Please adhere to the standard Almadallah Invoice Form structure *(Appendix C,)* and ensure including Service Name, Gross Price, Discount % and Net Price for each service item rendered as per agreed contract and consultation Deductible Fee and Co-participation Fees when applicable.

9. Reasons for claim denial or partially paid claims will be clearly stated in the Almadallah Reconciliation Report Form upon payment (provided on CD).
Almadallah is in the process of constructing electronic updates of claims services to be available to Providers under secure access.

D. VISITING PHYSICIANS PROTOCOL

Almadallah will cover the Fees of the Visiting Physician as follows after applying Co-participation Fee if applicable which is the responsibility of the member:

Network Visiting Physician and Network In-patient Facility: to charge as per the agreed respective Provider Tariff.

Out-of-network Physician and Network In-Patient Facility: Almadallah will pay the Network In-patient facility (Hospital) the agreed Surgery Fee as per Provider Tariff List and out-of-network Surgeon as per agreed Surgeon Fee on the Tariff List of the In-patient Facility Provider Tariff and the remainder to be charged to the patient.

Visiting Physician Form (Appendix I) must be signed by the patient and attached to the Claim Form.

E. PROVIDERS ORIENTATION SESSION

Almadallah shall invite representatives from the Providers' side (management/accounts management/insurance and claims department) that are recommended to attend an Orientation Program at our location in Dubai International Academic City.

The program is designed to explain methods and procedures to help synchronize processing claims between us and answer any inquiries that may have arisen.

F. INTERNATIONAL PROVIDERS

Service Tariffs will be recorded in our system in AED currency as per Contract Agreed Rates as per the conversion rate on date of Contract. Payments will be in US dollars or as per agreement and according to the currency conversion factor at the time of signing the Contract.

PHARMACIES

1. Pharmacist should check the Almadallah card with drearily packed stamped copy of the claim form and original prescription.

2. Pharmacist should verify the card for its validity, member category and for any specific Indications/conditions.

Please verify the member's Almadallah card with other valid personal ID for Almadallah's members visiting your facility.
For parents of the member or minors/children of the member, please verify with their personal ID or with the members ID

3. The **Expiry Date** is the date that the insured member's policy benefits and ability to receive direct billing services at your facility expires.
   Cards for some self-funded schemes do not have an expiry date
   Those cards are valid for unlimited period unless advised otherwise
   Cards with expiration dates

   The expiry date is inclusive of the end date.
   For example: Expiry Date = 31-Dec- 2010.
   - A consultation occurring on December 31, 2010 is inclusive up to 12 midnight.
     For chronic medication, when the prescribed period is beyond the expiration date, Almadallah must be billed until the expiry date only. The rest of the medicine has to be billed to the member directly.
   - Claims received by Almadallah relating to expired cards will not be paid and will be the provider's responsibility.

4. **Coverage**: Our members will have different coverage guidelines according to the following categories (any changes to the coverage shall be endorsed to all providers with two week notice). Reference to list of Categories in Appendix J.

5. Check that all fields in the Claim form are completed CORRECTLY AND CLEARLY by the hospital/clinic.

6. It is the pharmacy personnel's responsibility to check the member's card and complete any missing information in the Administrative part of the Claim Form.

7. **Prescriptions expire after 7 calendar days of date of prescription issued.**

8. **VIP cards**: Cards with A-VIP or A-V category denote that the card holder is a very important person and should be attended to immediately and with special assistance. **Reference to Pre-approval policy in Appendix J.**

9. Check if the prescribed medicines are excluded or require Pre-approval Reference in Exclusion List and Appendix J for Pre-approval indications.
   - **Pre-approval required for all Maternity prescriptions**
   - **Pre-approval required for all Dental prescriptions**
   - **Pre-approval required for all Optical Eye-wear**
   - **Pre-approval required for all Immuno-modulatory Drugs**
   - **More than 3 months' supply of prescribed Chronic medication**
   - **Pre-approval required for Hearing Aids (as per coverage guidelines refer to Appendix J)**

10. Please refer to Almadallah website at **www.almadallah.ae** for MOH/HAAD List and applicable policy and dispense the prescription strictly according to the directions of the physician and according to the Almadallah Healthcare Policy coverage

11. **Prescribed Herbal Medications are covered if available on the MOH/HAAD list. The updated MOH/HAAD list is under construction on the Almadallah Website.**

12. For medications that are not authorized or excluded, 100% of all related charges should be collected from the patient after applying the agreed upon Network Discount.

13. For eligible/authorized cases, any applicable Deductible Fee and Co-participation amount, (Refer to Appendix J) after applying the discount, must be collected from the patient and the eligible remainder should be billed to Almadallah.

14. A copy of the prescription can be provided to the patient upon request.

15. Original prescription should be attached to submitted claims or medications and dosage should be clearly mentioned on claim form, signed and stamped by the treating doctor.

16. Medications that are not medically necessary, not medically appropriate, not related to diagnosis and medications not prescribed by the treating physician are not coverable.

DIAGNOSTIC CENTERS

1. The member will present a stamped copy of the Claim Form drearily packed by the treating physician along with the copy of the Pre-approval Form if required.

2. Verify card for its validity, member category and for any specific indications/conditions. Provider has to check patient's identity card if available.

Please verify the member's Almadallah card with other valid personal ID for Almadallah's members visiting your facility.
For parents of the member or minors/children of the member please verify with their personal ID or with the members ID.

3. The Expiry Date is the date that the insured member's policy benefits and ability to receive direct billing services at your facility expires.

Cards for some self-funded schemes do not have an expiry date
Those cards are valid for unlimited period unless advised otherwise.
Cards with an expiry date
The expiry date is inclusive of the end date.
For example: Expiry Date = 31-Dec- 2010.

- A consultation occurring on December 31, 2010 is inclusive up to 12 midnight. For chronic medication, when the prescribed period is beyond the expiration date, Almadallah must be billed until the expiry date only. The rest of the medicine has to be billed to the member directly.
- Claims received by Almadallah relating to expired cards will not be paid and will be the provider's responsibility.

Coverage: Our members will have different coverage guidelines according to the following categories (any changes to the coverage shall be endorsed to all providers within two weeks in advance). Reference to list of Categories in Appendix J.

4. Check that all fields in the Claim Form are completed CORRECTLY and CLEARLY by the hospital/clinic. If there is any missing information in the Administrative part of the Claim Form, it is the provider's responsibility to write this information by checking the member's card.

VIP cards: Cards with A-VIP or A-V category denote that the card holder is a very important person and should be attended to immediately and with special assistance. **Reference to Pre-approval policy in Appendix J.**

5. Check if the diagnostic procedures are excluded or require Pre-approval.
Refer to Exclusion List and Appendix J for Pre-approval indications

6. If the requested diagnostic procedures require Pre-approval, (Refer to Appendix J for Pre-approval indications) it is the responsibility of the hospital/clinic referring the member to seek a Pre-approval. The copy of the approved stamped Claim Form, written approval letter and Pre-approval Form must be forwarded to your diagnostic center to then proceed with the service. Almadallah will not issue Pre-approvals without a referral form from the treating Network physician stating the medical necessity of the lab test or procedure.

7. For cases that are not authorized or excluded, 100% of all related charges should be collected from the patient after applying the agreed upon Network Discount.

8. For eligible/authorized cases, any applicable Deductible Fee and Co-participation amount, (Refer to Appendix J) after applying the discount, has to be collected from the patient and the eligible remainder should be billed to Almadallah. Refer to Appendix J.

9. If the sample for investigation is collected at the clinic and the facility does not have an in-house lab, the specimen can be sent to another lab/diagnostic center **within the Almadallah Network corresponding to the member's category** without the patient having to physically go there. A copy of the member's card must be attached to the stamped Claim Form and documents and the name of the Diagnostic Provider must be noted on the Claim Form.

10. All Pathology and Radiology Reports must be signed by a licensed Pathologist or Radiologist respectively in order to be valid and acknowledged with the submitted Claim.

11. For knee replacement claims, please include CD copy for Arthroscopies and scanned digital pre-operative and post-operative X-ray films.

12. ECG service will be paid only if it is submitted with graphic recording/typed report (stamped by the physician) or both.

13. EEG service will be paid only if it is submitted with graphic recording/typed report (stamped by the physician) or both.

14. Tympanometry will be paid only if it is submitted with graphic recording/both graph and typed report.

15. Audiometry will be paid only if it is submitted with graphic recording/both graph and typed report.

DENTAL CENTERS

All Dental services require Pre-approval including members with Category A-VIP or A V cards

1. Kindly check Almadallah card for dental benefit as you receive the patient.
   Dental: YES should be indicated on the card.

   Please verify the member's Almadallah card with other valid personal ID for Almadallah's members visiting your facility.
   For parents of the member or minors/children of the member please verify with their personal ID or with the members ID.

2. The Expiry Date is the date that the insured member's policy benefits and ability to receive direct billing services at your facility expires.
   Cards for some self-funded schemes do not have an expiry date
   Those cards are valid for unlimited period unless advised otherwise
   Cards with expiry dates
   The expiry date is inclusive of the end date. For example: Expiry Date = 31-Dec- 2010.
   - A consultation occurring on December 31, 2010 is inclusive up to 12 midnight. For chronic medication, when the prescribed period is beyond the expiration date, Almadallah must be billed until the expiry date only. The rest of the medicine has to be billed to the member directly.
   - Claims received by Almadallah relating to expired cards will not be paid and will be the provider's responsibility.

3. **Coverage:** Our members will have different coverage guidelines according to the following categories (any changes to the coverage shall be endorsed to all providers within two weeks in advance) . Reference to list of Categories in Appendix J.

4. Check that all fields in the Claim Form are completed CORRECTLY and CLEARLY by the hospital/clinic.

5. If there is any missing information in the Administrative part of the Claim Form, it is the Hospital/Clinic responsibility to write this information by checking the member's card.

   VIP cards: Cards with A-VIP or A-V category denote that the card holder is a very important person and should be attended to immediately and with special assistance. **Reference to Pre-approval policy in Appendix J**

6. For members with Dental Limits (Reference in Appendix J) call Almadallah at **04-4342322** or fax to 04-4342310 to check the dental limit and obtain a Pre-approval for all services under the **coverage guidelines for Dental benefits** *(See Dental Protocol Appendix G,).*

7. For cases that are not authorized or excluded, 100% of all related charges should be collected from the patient after applying the agreed upon Network Discount.

8. For eligible/authorized cases, any applicable Co-participation Fee/Deductible Fee/amount exceeding sublimit must be collected from the patient and the eligible remainder should be billed to Almadallah. The Invoice must reflect all the above.

9. For members responsible for Deductible Fee, (Reference in Appendix J)-the Deductible Fee is a fixed amount paid by the patient on the Consultation fee only. Dental consultation is waived when a procedure is performed. Therefore, in such cases no Deductible Fee shall be collected from the member.

10. For members responsible for Co-participation Fee, it is a percentage on the Net Price paid on all services. Almadallah will not be held responsible for failure to collect Co-participation fee. Co-participation is applicable on each and every service and should be collected after the discount has been applied.

ALMADALLAH EXCLUSION LIST

A. TREATMENT

1. Psychiatric, psychological, cognitive & senility related conditions, Senile dementia, Alzheimer's disease, developmental delays, learning disorders, attention deficit disorders as well as eating disorders, anorexia, obesity, obesity due to congenital, etc.
2. Suicide, self-inflicted injury, injuries caused from resisting legal arrest or committing an illegal act.
3. Vaccinations- **Refer to Appendix J**
4. Infertility, fertility, sexual dysfunction, sterility, menopause & osteoporosis related tests (except Dexa scan, ca+, vit D), procedures and prescriptions.
   ***Please* refer to Appendix J for coverage of the diagnosed cases of Fibroids, ovarian cysts, endometriosis, menstrual cycle problems or irregularities..**
5. Sexually transmitted diseases, AIDS & HIV, all hepatitis (**Except** Type A), herpes simplex II, pubic lice (**Except** in children), trichomoniasis, chancroid.
6. All Preventive care, Check-ups including well baby check-up, work permit related health screening **except** for the Antenatal screening tests such as but not limited to VDRL/HIV/HBV/HCV which are covered. **Refer to Appendix J**
7. All LASIK services and procedures.
8. Congenital diseases or malformation(s). **Refer to Appendix J**
9. Plastic, cosmetic surgery and treatment including any non-medically necessary nasal surgery, unless relating from an accident which occurs after the first enrollment date under the policy.
10. Substance abuse, addiction or alcoholism.
11. Radiation contamination.
12. Professional sports injuries and hazardous sports injuries, not job-related sports.
13. Hair loss, dandruff, hair transplant, hair disorders.
14. Home visits **except** in the case of emergency i.e. life threatening condition and/or requiring inpatient admission.
15. Genetic engineering and cloning.
16. Diseases designated by the WHO as epidemic.
17. Organ donation.
18. All Alternative Medicine such as but not restricted to: Acupunture, Acupressure, Osteopathy, Chinese Medicine, Chiropractic, Cupping Therapy, Homeopathy, Naturopathy, Ozone Therapy, Ayrovudics, Chiropody, Herbal Therapy, Reflexology, Aromatherapy, Hypnotherapy, Apitherapy, Colonic Cleansing, Color therapy, Gemstone Therapy, Holistic Health, Iridology, Breath Work, Kinesiology, Body Work, Buteyko, Flower Essences, Polarity Therapy, Therapeutic Touch, Yoga, Crystal Therapy, Orthomolecular Medicine, pranic Healing, Radionics, Therapeutic Humor, Traditional medicine, Herbal medicine, Nutrition medicine, Anthroposophical Medicine, Music Therapy, Ear Candles, Light Therapy, Magnetic Therapy, Massage Therapy, Qigong, Reiki, Counseling Therapy. **Refer to Appendix J**
19. Cerebral Palsy.
20. Prematurity below 36 weeks, Down syndrome, Thalassemia , Sickle Cell Anemia, G6PD , Biliary Atresia, G6PD , Biliary Atresia, Congenital Pyloric Stenosis, Congenital Septal Defect, Any congenital related test heart disease. **Refer to Appendix J**
21. Orthodontist services. **Refer to Appendix J**
22. Hazardous sports include but not limited to: All treatment of injuries and sickness consequent to the participation of the insured either as amateur or professional in hazardous sports such as shooting, motor sports, water sports (diving, jet skiing, power boats, water ski), horse riding activities (hunting, jumping, polo), climbing activities (mountaineering and rock climbing), winter sports (bob-sleighing, snowboarding, ice hockey, snow skiing, ski jumping), martial arts of all kinds. Etc.
23. Services or treatment in a long term care facility rehabilitation centre, spa, hydro, rest care , sanatorium, home care, nursing home for the aged, periods of quarantine and or isolation.
24. Ambulance services Except transfer patient from home to hospital in emergency case only & body of the patient who has expired from hospital to home

B. PHARMACY EXCLUSIONS

1. Fertility, infertility related medicines/agents.
2. Sexual dysfunction medications.
3. Hearing aids, eyeglasses, contact lens solutions, and accessories (unless otherwise specified). **Refer to** Appendix J
4. Psychotherapeutic medications (tranquilizers, sedatives, weakness or fatigue medications, etc.)
5. Appetite stimulants, appetite suppressants, dietary preparations.
6. Oral hygiene, non-medicated lozenges, oral sprays, dental and gum related medicine and products, etc.
7. Contraceptive medicines and products.
8. Cosmetic products, lotions, moisturizers, sunscreens, skin-lightening agents, masks, face cleansers, antiseptics, alcohol, etc.
9. Enzymes preparations, anti-oxidants, liver tonics.
10. Oral rehydrating solutions between the ages of 10 and 65 years.
11. Soaps, shampoos, cleansers.
12. Hair & scalp preparations.
13. Vaccinations/Immunizations. **Refer to** Appendix J.
14. Vitamins, minerals and supplements, **Except** those prescribed in adjunction with anti-biotics, prescriptions to treat vitamin deficiencies (e.g. resulting from anemia, diabetes), prescriptions to treat osteoporosis and antenatal vitamins for maternity patients. **Refer to** Appendix J
15. Smoking cessation, substance abuse medications.
16. AIDS/HIV, STD related medicines.
17. Collars, supports, braces, crutches, belts, wraps, stockings, external prostheses/devices, pumps, durable medical equipment for home use.
18. Pain balms, rubbificient, joint maintenance products and non-medicated preparations.
19. Bandages, disposables, glucose strips, lancets.
20. Glucometers, durable medical equipment and supplies.
21. Castor Oil, Cod Liver Oil, Clove oil, Eucalyptos Oil, Karvol, etc.
22. Diaper/Nappy rash cream, formula, baby supplies.
23. Artificial tears, Liquifilm, Dura tears..lubricants etc **Except** those prescribed in adjunction with anti-biotics and steroids eye drops
24. Normal Saline (Drops & sprays) for patients between the ages of 10 and 65 years **& Except** prescribed for Nebulization.
25. Herbal & homeopathic preparations, preventive medicines, **Except** those on the MOH list as listed in the Almadallah Pharmacy Guide.
26. Baby nutrition products.
27. Medications that are not medically necessary, not medically appropriate, not related to diagnosis and medications not prescribed by the treating physician.
28. Immuno-modulatory drugs and/or immunotherapy treatment or drugs including, but not limited to those listed in the table below, etc. unless medically necessary.

Basiliximab	- Biological response modifier
Daclizumab	- Biological response modifier
Rho (D) immune globulin	- Biological response modifier
Methyl Prednisone	- Glucocorticoid
Mycophenolate mofetil	- Immunomodulator
Sirolimus	-Immunomodulator
Cyclosporine	-Immunomodulator
Tacrolimus	-Immunomodulator
Azathioprine	-Immunomodulator
Etanercept	-Rheumatoid arthritis drug
Infliximab	-Rheumatoid arthritis drug

C. DIAGNOSTIC PROCEDURES

1. Fertility, Infertility related tests and procedures.
2. AIDS/HIV Related tests and procedures (including pre-operative) except in antenatal maternity check-up).
3. Preventive tests and checkups. Refer to Appendix J.
4. Screening tests and procedures (except for Maternity, please refer to Maternity Protocols at the end of the Manual).
5. Employment related check-ups.
6. Any tests not prescribed by a medical doctor licensed by MOH/HAAD and not under the Almadallah Network.
7. Any tests rendered after the Diagnosis (Consultation) of condition under the Exclusion List.

PRE-APPROVAL PROCEDURES AND INDICATIONS

A. PRE-APPROVAL INDICATIONS

(Refer to Appendix J)

APPLICABLE TO ALL CATEGORIES EXCEPT CATEGORY A VIP or A V

For Category A VIP or AV ALL Dental Services only require Pre-Authorization.

1. *IN-PATIENT / SAME DAY PROCEDURES*
   a. All In-patient admissions.
   b. All Daycare/short stay admission
   c. Major and minor surgeries.
   d. All work related injuries.
   e. Trauma cases (mentioning the history of the trauma is mandatory).
   Almadallah will cover up to AED 100/- per day for meal charges for all categories of Almadallah in-patient (individually for member and as per eligibility companion).

2. *OUT-PATIENT / PHARMACY*

(Applicable only for Maternity/ Optical / Dental Services)

   a. Pre-approval required for all out-patient services related to maternity/dental/optical benefits and as per policy Physiotherapy services.
   b. All Maternity related prescriptions.
   c. All Dental treatment related prescriptions.

3. *OUT-PATIENT / DIAGNOSTIC PROCEDURES*

(Applicable only for Maternity/ Optical / Dental Services)

Pre-approvals to be acquired at the doctor's office.

   a. Incase in-house diagnostic center is unavailable, member is referred to Network Diagnostic Center and Pre-approval should be acquired from the Diagnostic Center. All Dental and/or gum related tests and procedures.
   b. All Maternity tests and procedures (see Maternity Protocols on page).
   c. All Optical i.e. Refractory Tests. Kindly note that Refraction Tests are considered as a consultation and either Deductible Fee and/ or Co-participation Fee is applicable as per policy.

4. *OUT-PATIENT / PHYSIOTHERAPY*

Refer to Appendix J. Physiotherapy will only be covered on the **basis of medical necessity as a part of a treatment plan clearly stated on the claim form referred by a network treating physician.** (Physiotherapy sessions form (*See Appendix G*) **must** be filled by the Provider and signed by the patient and submitted within the due date limit (as per contract).

5. HOMECARE NURSING

Almadallah Healthcare Policy covers 2-6 weeks Home Nursing as per the Group Policy and treating physician's medical report. Pre-approvals are required for all Homecare Nursing Services.

B. PRE-APPROVAL PROCEDURES

Pre-approvals are valid for a maximum of **10 calendar days** during which the pre-authorized services should be rendered. If the service was not rendered or if it was rescheduled for another day, then **the same request (Claim Form)** has to be re-faxed or verbally re-approved.

1. EMERGENCY IN-PATIENT

a. Immediately attend to the patient.
b. Stabilize the condition.
c. Obtain a verbal approval within 24 hours by calling the Almadallah Call Center at **04-4342322** for admission and managing the condition. Provider should fax the duly completed Almadallah Claim Form to Almadallah at 04-4342310, along with relevant medical reports and test results to justify the service being requested for further evaluation of approval request.
d. The Claim Form and any supporting documents such as the Pre-approval document, Medical Reports, Discharge Summary and Invoices **MUST** be attached when submitting Claims for payment.

2. NON-EMERGENCY IN-PATIENT CASES

a. Send the Claim Form and any supporting documents (medical reports) by fax to Almadallah at 04-434 2310.
b. Wait for the written reply.
c. Almadallah will reply by faxing the same Claim Form with the evaluation results back within 24 hours.
d. The Claim Form and any supporting documents as the Pre-approval document, Medical Reports, Discharge Summary and the Invoices **MUST** be attached when submitting Claims for payment.

3. OUT-PATIENT SERVICES

e. Services listed under Pre-approval indications require **Verbal Approval first** to be obtained by calling Almadallah at **04-434 2322. Please note that all calls are recorded.**
f. Register the name of the person granting the approval and proceed with the medical service. Verbal Approval form will be e-mailed or faxed within 2 hours. **Kindly provide correct e-mail or fax numbers to prevent discrepancies by completing Provider Information Excel Sheets that can be found on website. (Appendix L)**
g. The Claim Form and any supporting documents as the Pre-approval document, Medical Reports and the Invoices **MUST** be attached when submitting Claims for payment.

SECTION TWO

CLAIM SUBMISSION AND RECONCILIATION

A. CLAIMS SUBMISSION

1. Claims must reach Almadallah no later than 30 days from end of the month from date of service or patient discharge or as indicated in the contract for eligibility of payment.
2. Submitted Claims should be clearly and completely filled and all relevant supporting documents as medical report, results of all investigations rendered, original prescriptions, discharge summaries (for In-Patient) must be attached.
3. Any Claim received by Almadallah after the Contract agreed submission or re-submission period will incur a 1% surcharge per month up to a maximum of 3 months (up to 3 re-submissions, within the 3 months) that will be applicable on the late claimed amount.
4. Please use the same Claim Form for Dental Consultations and Dental Procedures rendered on the same day.

- **Dental Claims totaling 10,000AED and above per patient, collectively *per 2 weeks* must be accompanied with pre-procedure and post- procedure X-rays with the patient name and date of service.**
- **For knee replacement claims, please include CD copy for Arthroscopies and scanned digital pre-operative and post-operative X-ray films.**
- **ECG service will be paid only if submitted with graphic recording/typed report(stamped by the doctor) or both.**
- **EEG service will be paid only if submitted with graphic recording/typed report(stamped by the doctor) or both.**
- **Tympanometry will be paid only if submitted with graphic recording/both graph and typed report.**
- **Audiometry will be paid only if submitted with graphic recording/both graph and typed report**
- **All reports must be signed by Pathologist / Radiologist or they won't be evaluated.**
- **Almadallah would like to ensure correct payments are made to the Diagnostic Provider where the service has been rendered. Please mention the name of the Diagnostic Provider where the Diagnostic Test will be done when requesting for Pre-approval. *Almadallah will ensure payment to the Provider noted on the Pre-approval Form.***
- **50% discount to be applied on the 2nd Surgical Procedure performed at the same sitting.**
- ***Applicable on Optical only*. Refraction test report (original or photocopy) must be attached or the result should be clearly written on Claim Form. It is valid for 6 months.**

5. Please submit each Batch of Claim Forms with the following:

   a. The Original Itemized Invoice (must include Name of Service, Gross Price, Discount %, Net Price as per Contract)
   b. Detailed Statement Of Account.

   Ensure the same correct information (Date, Patient Name, Card Number, Invoice Number, Charges) are stated on the Claim Form, Invoice, Detailed Statement of Account.

6. Individual Claims (and accompanied documents) should be separated and batched per ***Payer.***

7. Each batch should be accompanied by **Detailed Statement of Account** Form for that payer. The Detailed statement of Account should enlist the details of all physical claims submitted for that particular payer within the allocated billing period. *(See Appendix D,).*

8. Payments are provided as per the terms of the Network Agreement. Cheques along with Payment Orders, Transaction Details and Batch Summary Report will be (provided on CD).

9. **Upon receiving Batch from Provider, Almadallah will e-mail an acknowledgment letter noting details of Batch received and upon need will give 7-days' notice requesting for attention to attend to technical discrepancies.**

B. PROCEDURE FOR RE-SUBMISSION

1. Re-submission should be made within 30 days of receiving the returned Claims or as per contract. Please complete with Resubmission Form accordingly (See Appendix F) and use a new Re-submission Report for each Batch.

2. Re-submit the missing documents as requested in the Reconciliation Report and include a photocopy of the returned Claim Forms along with a copy of the Reconciliation Report *(See Appendix E,)* submitted by Almadallah. Please use the same Batch Number on each Re-submission Report and **do not mix Batches**. Therefore, for a few Claims of different Batches, segregate the Claims according to Batch number using a new Re-submission Report for each Batch. Any Claim received by Almadallah after the Contract agreed submission or re-submission period will incur a 1% surcharge per month up to a maximum of 3 months (up to 3 re-submissions, within the 3 months) that will be applicable on the late claimed amount.

After evaluation, Almadallah can return/reject Claims due to the following reasons as will be stated clearly on the Reconciliation Report Form submitted at the time of payment:

1. Technical Denial**:** (Missing Document(s): A CD of scanned claims will be couriered to the provider. (Reason for denial will be mentioned in the Reconciliation Report).

2. Partial Denial: Claims amount is partially denied as per policy terms and conditions. A CD of scanned claims will be couriered to the provider along with the Payment Order. (Reason for denial will be mentioned in the Reconciliation Report).

3. Full Denial: The claim amount is entirely denied as per policy terms and conditions. A CD of scanned claims will be couriered to the provider along with the Payment Order. (reason for denial will be mentioned in the Reconciliation Report).

4. Final Denial: These are denials after re-evaluation of re-submitted claims. The decisions are final and re-submissions are no longer considered.

PROTOCOLS

DENTAL PROTOCOLS

Applicable to all Categories that are eligible for Dental Services. Refer to Appendix J.

1. In order to prevent discrepancies between the member and the provider, and upon the request of our Clients, it is requested that all patients sign the attached Dental Procedure Declaration form BEFORE any Procedure (including x-rays/testing) is rendered, and that this form is attached to the Pre-approval Form to be sent back to us when submitting the claims. If another procedure is decided further into the treatment, then accordingly the patient must sign another Dental Procedure Declaration form as needed as per the treatments that will be listed in the Pre-approval Form *). In the case a procedure is cancelled after you have obtained Pre-approval, kindly re-contact the Almadallah Call Center to cancel the Pre-approval request.*

2. **Dental Routine Coverable Treatment for Children and Adults :**

- Extractions
- Fillings, Inlays and Onlays
- Scaling and Polishing
- Root Canal Treatments
- Gum Surgeries
- Crowns and Bridges (ceramic and zirconia materials)
- Related Medicines
- X-rays if part of the treatment

- *The Deductible Fee is a fixed amount paid by the patient on the Consultation only.* **Refer to Appendix J**
- *Dental Consultation is waived when a procedure is performed. Therefore, in such cases no Deductible Fee shall be collected from the member as per Contract.*
- *Please use the same Claim Form for Consultations and Procedures rendered on the same day. Claims totaling 10,000AED and above per patient, collectively per 2 weeks must be accompanied with pre-procedure and post-procedure X-rays with the **patient name and date of service** clearly noted.*
- ***Implants, Dentures, Veneers, Bleaching, Fluoride Treatment, Prosthodontics and Fissure Sealants are excluded items.***

3. **In case of emergency** caused by accidents (external force/injury) if reported within 48 hours., accordingly dental services will be covered under the medical aggregate limit.

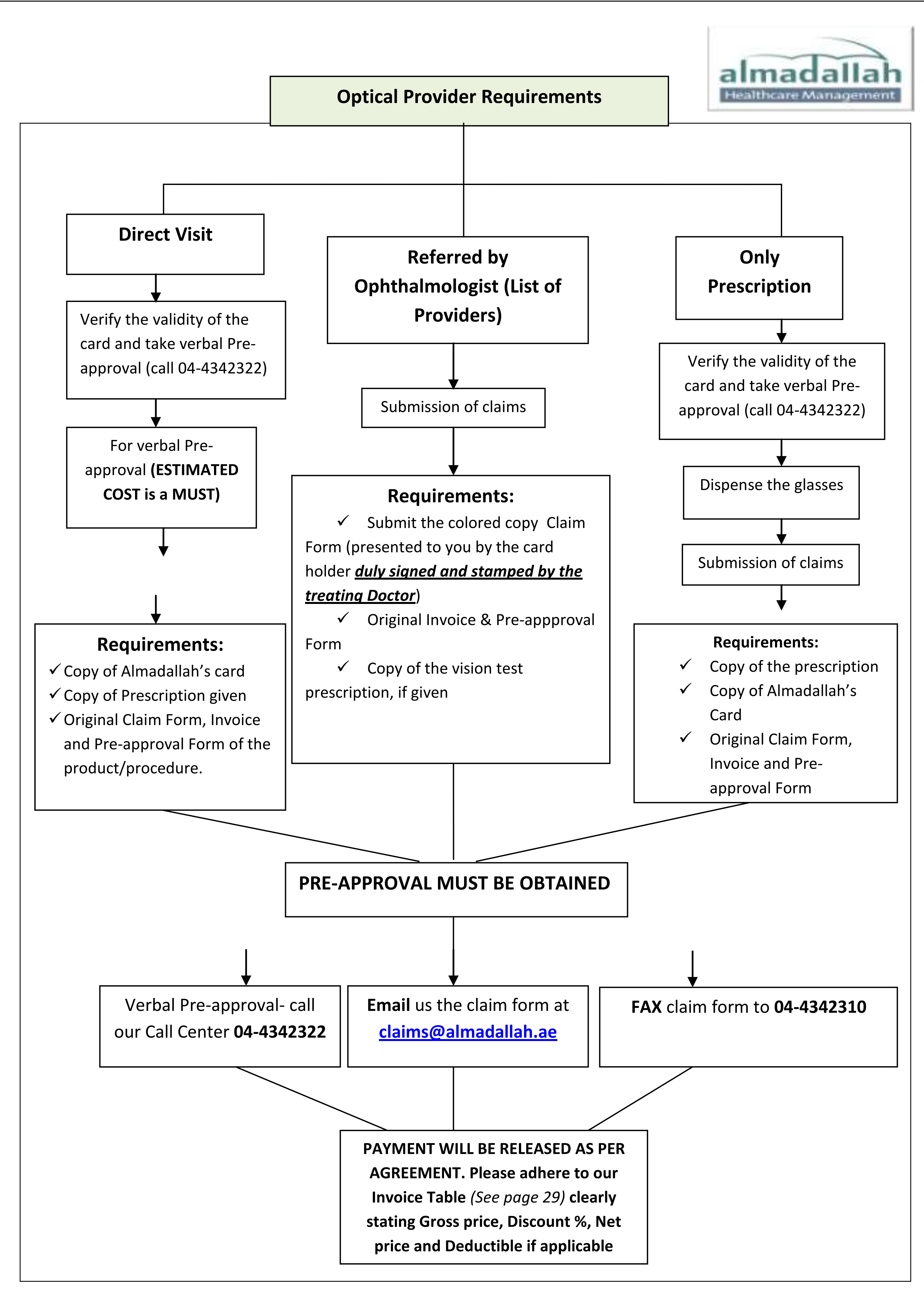
OPTICAL PROTOCOLS

Applicable to all Categories that are covered with no exception

1. **Coverable Optical Services**

- **Optical Eye Exam/Refraction Test** (considered a consultation to which 50AED Deductible Fee is applicable and may be performed by Ophthalmologist or Optometrist) Refraction test report must be attached or the result should be clearly written on claim form. It can be original or photocopy. It is valid for 6 months.
- Eyeglasses + *Frames (documented for sight either from treating Physician or Computerized Autorefractometry)
  *Refer to Appendix J
- Colored Contact lenses with power.
- Prescription sun glasses (with power).
- Photochromatic glasses (optical lenses).
- Daily disposable contact lenses (optical).
- Specialized contact lenses for Astigmatism
- Plano optical with power (concave/convex) lenses.
  Please Note: Lens with power 0.25 will only be covered in case of medical necessity as prescribed by a Network Ophthalmologist.

2. **Non-Coverable Optical Services**
   Multi-tinting is considered cosmetic and is not covered.
3. Other Medical Diseases of the eye treated by the ophthalmologist, such as Infection, Cataract, Corneal Abrasions, Glaucoma, Macular Diseases, Conjunctivitis and others will be covered under the medical aggregate limit and not under the optical limit.
4. **Optical Requirements:**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Optical Provider Requirements
Direct Visit
Verify the validity of the card and take verbal Pre-approval (call 04-4342322)
For verbal Pre-approval (ESTIMATED COST is a MUST)
Requirements:
✓ Copy of Almadallah's card
✓ Copy of Prescription given
✓ Original Claim Form, Invoice and Pre-approval Form of the product/procedure.
Referred by Ophthalmologist (List of Providers)
Submission of claims
Requirements:
✓ Submit the colored copy Claim Form (presented to you by the card holder duly signed and stamped by the treating Doctor)
✓ Original Invoice & Pre-appproval Form
✓ Copy of the vision test prescription, if given
Only Prescription
Verify the validity of the card and take verbal Pre-approval (call 04-4342322)
Dispense the glasses
Submission of claims
Requirements:
✓ Copy of the prescription
✓ Copy of Almadallah's Card
✓ Original Claim Form, Invoice and Pre-approval Form
PRE-APPROVAL MUST BE OBTAINED
Verbal Pre-approval- call our Call Center 04-4342322
Email us the claim form at claims@almadallah.ae
FAX claim form to 04-4342310
PAYMENT WILL BE RELEASED AS PER AGREEMENT. Please adhere to our Invoice Table (See page 29) clearly stating Gross price, Discount %, Net price and Deductible if applicable

MATERNITY PROTOCOLS

1. OUT PATIENTS

APPROVE	DENY
1. Doctors Consultation **2.** 2D and 3 D U/S **3.** CBC/U/E **4.** Blood Group and RH **5.** Direct / Indirect Comb's Test **6.** Rubella (Blood Test) **7.** Urine Examination **8.** Glucose Tests (fasting and Postprandial) **9.** Vitamins, Minerals and Supplements **10.** Antenatal Tests for ➢ HIV ➢ RPR ➢ Hepatitis B and C Virus ➢ V.D.R.L ➢ Any other STD screening tests **11.** Vaccinations: Refer to Appendix J as per WHO/MOH protocols.	**1.** 4 D scan **2.** Screening for congenital conditions, amniocentesis etc., **3.** Anti D injection **4.** Vaccination i.e. Rubella

2. IN PATIENTS

APPROVE	DENY
Maternal 1. Approve for delivery (NVD + CS) 2. Spontaneous Abortions 3. Miscarriage up to the corresponding (to category) yearly maternity limit. 4. Taking into account utilized antenatal services as part of calculation under maternity 5. Approve for post natal services if maternity limit has not been utilized. Neonatal (under Maternal or baby aggregate following pre-approval) 1. Neonatal circumcision 2. Neonatal vaccination -K). **Refer to Appendix J** 3. Newborn coverable charges	If maternity limit had been utilized Neonatal Screening Test

OTHER PROTOCOLS

Please refer to Appendix J for the Protocol applicable to Physiotherapy and Alternative Medicine services.

CONTACT DETAILS

For Pre-approvals, please call the Call Center: 04-434 2322 (24 Hours/7 Days A Week)

For Administrative Issues and to Order Claim Forms, please call the reception: 04-434 2311 (8:00am-4:00pm)

Fax: 04-434 2310

For network related issues / inquiries Fax: 04 4477947

Website: www.almadallah.ae

Claims Inquiries: claims@almadallah.ae

Network Inquiries / Issues: network@almadallah.ae

Account Inquiries: accounts@almadallah.ae

Claims Resubmission: mary.eusebio@almadallah.ae **and copy** katrina.hassan@almadallah.ae **for medical affairs and claims issues**

Reconciliation: anne.calinisan@almadallah.ae **and copy** katrina.hassan@almadallah.ae

Mailing Address for Claim Submission:

Almadallah Healthcare Management

P.O.Box: 31712.

Dubai International Academic City

Building 3, Office 8

Dubai, United Arab Emirates

APPENDICES

Appendix A – Almadallah Claim Form

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Claim Form

استمـــارة المطالبة

No:

Please complete all the fields

Tel: +9714 434 2311 Fax: +9714 434 2310, Help Line for 24 Hours: 04 434 2322

Date: / / | Healthcare Provider:

PATIENT INFORMATION

Patient's Name (as on card): | ❑ Mr. ❑ Mrs. ❑ Ms.

Card # | Policy No. | Birth date: / / (dd mm yy) | Sex: ❑ M ❑ F

INFORMATION *To be completed by Physician*

Date of present symptoms: / / (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 Findings:

Cause ❑ Physical Illness ❑ Accident ❑ Maternity ❑ Preventive ❑ Psychiatric ❑ Dental ❑ Work Related

❑ Other(s), Explain

Assessment/Diagnosis ❑ Acute ❑ Chronic ❑ Confirmed ❑ Suspected

1-

2-

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:
Estimated Cost:	

IN-PATIENT

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

Length of stay: | 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:	***Patient/Guardian signature***
Tel./Fax:	
✍Signature & Stamp	
Date:	*Date:*

Claims should be submitted with supporting documents within 30 days from date of service. AMD-E-P-1(10/03/2009)

Appendix B – Almadallah Verbal Pre-approval Form

Print Now | Save As | Send Mail

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Verbal Pre-Authorization

PATIENT INFORMATION

Date		Time	
Name		Card No	
Claim Type		Claim No	
Provider			

OBJECTIVE / ASSESSMENT

Diagnosis	
ICD	
CPT	
Cause	
No of items	

SERVICES

Total Records :2

Service Code	Service Description	Net	Remarks

Estimated Cost		Deductable	
Co Payment		Doctor	
Communication			
Authorizer			
Claim Action			
Remarks			

Appendix C – Almadallah Invoice Form

Almadallah Healthcare Management

Invoice

Providers Name:	Patients Name:
Providers Address:	Patients Card Number:
Providers Phone Number:	Invoice Date:
Accountant:	Invoice Number:

SN	Service Code	Service Description	Quantity	Gross Amount	Discount %	Discount Amount	Patients Share		Net Amount
							Deductible	Copay	
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									
11									
12									
13									
14									
15									
16									
17									
18									
19									
20									
Notes:			Total (AED)						

PO Box 31712, Dubai International Academic City, Block 3, Office 8, Dubai -UAE www.almadallah.ae **For Billing** Phone: 04-434 2311 Fax:04-434-2310 Email: billing@almadallah.ae

Appendix D – Almadallah Detailed Statement of Accounts Form

Detailed Statement Of Account

Almadallah Healthcare Management

Batch # (for Almadallah use)		Providers Name	
Total # of Claims Submitted		Name Of Contact Person	
Billing Period Dates: From		Email Address	
To		Telephone Number	
Submission Date		Fax Number	

SN	Date of Service	Invoice No.	Claim Form No.	Patient Name	Gross Amount	Discount Amount	Patient's Share		Net Amount
							Deductible	Copay	
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									
11									
12									
13									
14									
15									
16									
17									
18									
19									
20									
				Total (AED)					

Notes:

PO Box 31712, Dubai International Academic City, Block 3, Office 8, Dubai -UAE www.almadallah.ae **For Billing** Phone: 04-434 2311 Fax:04-434-2310 Email: billing@almadallah.ae

Appendix E – Almadallah Reconciliation Report Form

almadallah Healthcare Management

Reconciliation Report

Sl No	Claim Number	Invoice number	Patient	Claimed Amount	Approved Amount	Amount Denied	Status	Remarks from Al Madallah (related to reconciliation report)

almadallah Healthcare Management

Providers Name

Batch Number

Claim No	
Card No	
Patient	
Date	
Invoice	

Service Description	Type	Net	CollectedAmt	ClaimedAmt	ApprovedAmt	Denied Amt	Status	Remarks (Related to Reconciliation Report)
Bill No :								
Bill No :								

Appendix F – Almadallah Resubmission Report

Resubmission Report in reference to:

Batch Number:
Providers Name:

S/No.	Member's Name	Card number	Claim form Number	Providers Invoice Number	Amount Claimed	Amount Approved	Amount Denied	Clarification for Resubmission

NOTE: *While resubmitting the claims, kindly attach the supporting documents, if required with the photocopy of the claim form,and a copy of reconcilliation report submitted by Al Madallah.*

Version 1 17/12/2009 AM/NN

Appendix G – Dental Declaration Form

Dental Procedure Declaration

بيان علاج الأسنان

(Applicable for each Dental Session)

Kindly read and sign the below Treatment Plan Declaration required by Almadallah for Dental healthcare coverage before receiving dental services. Thank you for your cooperation.

- I hereby confirm that the Treating Clinician and the Medical Team discussed and explained the aim and the nature of the Treatment Plan in addition to the side effects which may result during the treatment; accordingly, I hereby authorize the Treating Clinician and the Medical Team to proceed with the stages of the Treatment Plan mentioned in the ***Pre-authorization Form***.
- I hereby confirm that the Treating Clinician and the Medical Team have given me the full chance to ask questions about the Treatment Plan and the possible treatment options regarding my case; accordingly, I hereby confirm that the information communicated to me is sufficient to give my agreement to the proceed with the stages of the Treatment Plan mentioned in the **Pre-authorization Form**.
- I hereby authorize the Treating Clinician and the Medical team to make any further necessary medical treatments which may emerge during the course of the treatment such as Root Canal Therapy; accordingly, the cost of such treatments will be added to the Treatment Plan.
- I hereby confirm my full agreement for the Treatment Plan mentioned in the ***Pre-authorization Form***
- **In case member prefers to discontinue Pre-approved dental treatment due to any reason, Almadallah Healthcare Management MUST BE informed by the *Provider* within 10 calendar days.**

- **نحن في المظلة نلزم كل مريض على قراءة و إمضاء "إقرار خطة المعالجه" قبل بدء تلقي المعالجة للحالات داخل التغطية . وشكرا لحسن تعاونكم.**
- أقر أنا أن الطبيب المعالج والفريق الطبي قد قاما بمناقشة وشرح هدف وطبيعة خطة المعالجة بالإضافه إلى الأعراض الجانبية التي قد تنتج أثناء المعالجة وبناء عليه فإنني أفوض الطبيب المعالج والفريق الطبي على البدء بمراحل خطة المعالجة المذكورة في **الموافقة الخطية** .
- أقر أنا أن الطبيب المعالج والفريق الطبي قد قاما بإعطائي الفرصة كاملة لطرح الأسئله بخصوص خطة المعالجة والبدائل العلاجية المحتملة الخاصة بحالتي وبناء عليه فإنني أقر أن المعلومات التي تلقيتها كافية لإبداء موافقتي على البدء بمراحل خطة المعالجة المذكورة في **الموافقة الخطية**.
- أفوض الطبيب المعالج والفريق الطبي على إجراء أي علاجات طبية إضافية ضرورية قد تطرأ أثناء مراحل المعالجة كوجوب إستئصال العصب والمعالجة الجذرية وبناء عليه سوف تضاف تكلفة تلك المعالجات إلى **خطة المعالجة** المذكورة آنفاً.
- أقر بمسؤليتي الكاملة على الموافقة على **خطة المعالجة** المذكورة
- **في حال قرر المشترك إيقاف خطة العلاج؛ فانه يتوجب على *الطبيب المعالج* إبلاغ المظلة خلال 10 أيام عمل .**

Name of Patient: أسم المريض:

____

Signature of Patient: توقيع المريض: Date: التاريخ :

____________________ ____________________

NAME OF PROVIDER

____

Appendix H – Physiotherapy Sessions Declaration Form

almadallah
Healthcare Management

PHYSIOTHERAPY SESSIONS DECLARATION FORM

Your satisfaction, our specialty

NAME OF PROVIDER: ______________________________

PHYSIOTHERAPY SESSIONS

PATIENT DETAILS	NO.	DATE OF SERVICE	CLAIM FORM NO.	PRE-APPROVAL CLAIM FORM NO. (IF APPLICABLE)	PATIENT'S SIGNATURE (AFTER SERVICE DONE)	REMARKS (TOTAL NO. OF SESSIONS)
FULL NAME:	1					
CARD NO:	2					
MOBILE NO:	3					
DATE OF REFERRAL:	4					
REFERRAL DOCTOR:	5					
THERAPIST NAME:	6					
DIAGNOSIS:	7					
OTHER DETAILS:	8					
	9					
	10					
	11					
	12					
	13					
	14					
	15					
	16					
	17					
	18					
	19					
	20					

______________________________ DOCTOR'S STAMP & SIGNATURE

______________________________ PHYSIOTHERAPIST'S SIGNATURE

Appendix I – Visiting Physician Form

Visiting Physician Coverage Indications

مؤشرات تغطية الطبيب الزائر

(Applicable for patients to receive Visiting Physician services)

تطبق على المريض الذي يتلقى خدمات الطبيب الزائر

We, at Almadallah Healthcare Management, would like to offer our members the services that will best meet your medical needs.
Kindly sign that you have read and understood the below indications as required by Almadallah before receiving services from Visiting Physicians. Thank you for your cooperation.

نحن في شركة المظلة لإدارة التأمينات الصحية ,نود أن نقدم لأعضائنا أفضل الخدمات التي من شأنها تلبية إحتياجاتكم الطبية .

يرجى قراءة وتوقيع الطلب لشركة المظلة بعد فهم ما يحتويه من نقاط قبل تلقي الخدمات من الطبيب الزائر . نشكر لكم حسن تعاونكم .

A. Network Physician

As per our healthcare scheme, Almadallah covers the costs per our Policy indications and according to the Provider agreed tariff rendered by the treating Network physician at the Network facility as listed with Almadallah. Co-participation Fee if applicable is the responsibility of the member.

أ. طبيب الشبكة

كما لدينا خطة في مجال الرعاية الصحية حيث أن المظلة ستغطي التكاليف على حسب السياسة المتبعة ووفقاً للأسعار المتفق عليها لأطباء الشبكة الطبية على النحو المتفق عليه مع المظلة. رسوم المشاركة هي مسؤلية العضو .إن وجدت .

B. Visiting Physician

Almadallah will cover the Fees of the Visiting Doctor as per the rate charged by the Network physician at that facility.

Any difference in the amount charged by the Visiting Physician and Co-participation Fee, if applicable, will be the responsibility of the Patient.

Please do not hesitate to contact Almadallah regarding any clarification you may need.
Wishing you always the best of health.

ب. الطبيب الزائر

المظلة سوف تغطي رسوم الطبيب الزائر على حسب الأتعاب التي يتقاضاها طبيب الشبكة .

أي فرق في المبلغ الذي يتقاضاه الطبيب الزائر ورسوم المشاركة إن وجدت سوف يكون من مسؤولية المريض.

لا تتردد في الإتصال بالمظلة بخصوص أي توضيح قد تحتاج إليه .

متمنين لكم دوام الصحة.

Name of Patient: إسم المريض :

____

Signature of Patient: توقيع المريض

____

Date: التاريخ :

____

Name of Provider: إسم مقدم الخدمة :

____

شركة ذات مسؤولية محدودة منطقة حرة FZ LLC
مدينة دبي الجامعية، بناية ٣ مكتب ٨، هاتف : ٢٣١١ ٤٣٤ ٤ ٩٧١+، فاكس : ٢٣١٠ ٤٣٤ ٤ ٩٧١+، ص ب ٣١٧١٢، دبي، الإمارات العربية المتحدة
Dubai Academic City, Building 3 Office 8, Tel.: +971 4 434 2311, Fax: +971 4 434 2310, PO Box 31712, Dubai, United Arab Emirates
www.almadallah.ae

Appendix J – Group Policy Indications Summary

Group Policy Indications Summary

Please find below a reference to distinguish and facilitate policy implementation for Dubai Government Members and for Dubai Holding Members.

Almadallah Member Health Card

Dubai Government **Member Card Example:**

Group Logo → GOVERNMENT OF DUBAI | almadallah Healthcare Management

Member's Card Number → Card No. 98765432

Policy Code: GM001DA ← Policy Code: For Almadallah internal use

Name : XXX

D. O. B. : 03-Apr-11

National ID No.:

Category: A ← Member Category: AVIP (or AV), A, B, C & D

Healthcare Provider Network: GN +, GN or RN → Network: GN +

Expiry Date: ← Expiry Date: NONE

Deductible: Amount to be collected from the Patient on Consultation applicable as per policy → Deductible: Only for DHA AED 20 PH: 20%

Co-Participation: 20% ← Co-participation Fee: % indicated

Optical: 50% F&CL Dental: 30% Maternity: N/A

Note: Pre-approval required for Dental, Maternity, Optical and Inpatient, except for A-VIP Category ← Pre-approval: as per policy indications

Dubai Holding **Member Card Example:**

Group Logo → DUBAI HOLDING | almadallah Healthcare Management

Member's Card Member → Card No. 9876544

Policy Code:PM101E1 ← Policy Code: For Almadallah internal use

Name : XXX

D. O. B. : 02-Jan-80

National ID No.:

Category: 1 ← Member Category: A, 1, 2 & 3

Healthcare Provider Network: GN +, GN or RN → Network: GN+ (AH 20% Co-Par)

Expiry Date: 30-Apr-12 ← Expiry Date: As indicated

Deductible: Amount to be collected from the Patient on Consultation applicable as per policy → Deductible: 50/- AED

Co-Participation: NIL ← Co-participation Fee:% indicated

Optical: Yes (No Frames)Dental: Yes Maternity: N/A

Note: Pre-approval required for Dental, Maternity, Optical, Inpatient & Hearing Aids ← Pre-approval: as per policy indications

General Healthcare Policy Distinctions

DUBAI GOVERNMENT ENTITIES

PHYSIOTHERAPY

-Requires Physician's Prescription

-Pre-approval required for more than 6 prescribed sessions

DENTAL SERVICES

- All Categories covered as per policy up to sub-limit.
- Dental Check-ups not covered

ALTERNATIVE MEDICINE

- Not Covered

OPTICAL SERVICES

- All Categories covered as per policy up to sub-limit.

GYN. RELATED SERVICES

- Covered as per policy Co-participation percentage policy payable by member: ***(Fibroids, ovarian cysts, endometriosis, menstrual cycle problems or irregularities) Category A VIP or A V 70 %, Category A 75%, Category B 80 %, Category C 85 % and Category D 90 %***

CONGENITAL DISEASES

-Not covered

VACCINATIONS

- Newborn Vaccinations covered only for Newborn up until discharge from Hospital
- Tetanus and Anti-Rabies as per medical necessity

HEARING AIDS

- Not Covered

IN-PATIENT COMPANION CHARGES

- Covered for person accompanying female or child patient under 16yrs of age inclusive of food and bed in the same room. Almadallah will cover up to AED 100/day for meal charges for in-patient companion to cover breakfast, lunch and dinner)

NEWBORN CHARGES

-Covered on mother's card for first 60 days

DUBAI HOLDING MEMBER ENTITIES

PHYSIOTHERAPY

- Requires Physician's Prescription
- Pre-approval required for all Out-patient sessions

DENTAL SERVICES

- All Categories (Except Category 3) covered as per policy up to sub-limit.
- Dental Check-ups are covered with Preapproval
- Orthodontic services covered for Cat A only

ALTERNATIVE MEDICINE

- All Categories (Except Category 3)

-Requires Physician's Prescription

- 20% Co-participation Fee and Preapproval required (except Category A)

OPTICAL SERVICES

- All Categories (Except Category 3) covered as per policy up to sub-limit.

-Optical Frames not covered

GYN. RELATED SERVICES

-100% percentage as per policy indications

CONGENITAL DISEASES

-Covered as per policy

VACCINATIONS

- Newborn Vaccinations covered as per MOH/WHO list
- Travel Vaccinations for employees on approved business trip. Pre-approval required

HEARING AIDS

- Covered as per policy.

IN-PATIENT COMPANION CHARGES

- Not Covered

NEWBORN CHARGES

-Covered on Reimbursement for first 90days.

Pre-approval Policy Distinctions

DUBAI GOVERNMENT ENTITIES

-In-Patient Hospitalization

-Outpatient Services:

- Day Care Surgery
- Physiotherapy more than 6 sessions
- All Maternity
- All Dental
- All Optical

-Pharmacy and Diagnostic related to:

- All Maternity
- All Dental
- All Optical
- Pharmacy more than 3months supply

DUBAI HOLDING MEMBER ENTITIES

-In-Patient Hospitalization

-Outpatient Services:

- Day Care Surgery
- All outpatient Physiotherapy
- All Maternity
- All Dental
- All Optical
- All Alternative Treatment

-Pharmacy and Diagnostic related to:

- All Maternity
- All Dental
- All Optical
- Hearing Aids
- Pharmacy more than 3months supply

Co-participation Fee Policy (applicable only to Dubai Government Entities)

DUBAI GOVERNMENT POLICY

APPLICABLE FOR CATEGORIES A, B, C & D	
In-Patient/Out-Patient Medical including maternity services	**20% Co-participation**
Pharmacy In-Patient/Out-Patient Medical including maternity services	**20% Co-participation**
Dental All dental services: accidental/routine (Applicable limits for each category)	**30% Co-participation**
Optical Applicable limits for each category	**50% Co-participation for all contact lenses and frames**
Deductible Applicable for consultations	**In DHA 20AED only** **Not applicable in other networks**
Note : Mortal remains	**Fully Covered**
Second Opinion	**Fully Covered**

Note: Co participation Policy and Pre-Authorization policy do not apply to category A-VIP except for all Dental services

Deductible Fee (AED 50) is only applicable to Category A-VIP on consultation

Appendix K – Checklist for Claims Completion

almadallah Healthcare Management

CHECKLIST for CLAIMS COMPLETION

Sr.#	***Points to be Verified & Approved*** *1. By the* ***Receptionist*** *before Patient leaves the Providers Office* *2. Batch of Claim Forms is re-checked by the* ***Billing person*** *before Claim Submission*	***Please check (√) boxes below***
1	All Forms have the ***Provider's Name***	
2	All Forms have the ***Date Of Service***	
3	All Forms have the ***Patient Almadallah Card Number***	
4	All Forms have the ***Patient Name***	
5	All Forms have the ***Diagnosis*** and ***Actual Cost***	
6	All Forms have ***Patient's Signature***	
7	All Forms have the ***Doctor's Signature***	
8	All Forms have the ***Doctor's Stamp***	
9	**Almadallah Card Copy** is ATTACHED to Claim Form	
10	**Pre-Authorisation Form** is ATTACHED to Claim Form (when applicable). Pre-Authorization Form is valid 10 Calendar Days from Claim Form Date of Service.	
11	Medical Report &/or Dental Procedure Declaration are ATTACHED (when applicable)	
12	**Original Prescription** is ATTACHED to Claim Form *Pharmacy Prescription is valid 7 Calendar Days from Claim Form Date.* *Optical Prescription is valid for 6 months from date of Eye Test.*	
13	All Prescriptions have the Doctor's Provider Stamp	
14	**Invoice Form** is ATTACHED to Claim Form	
15	*Name* and *Card number* of the Patient on the Invoice & on the Claim Form are same	
16	Invoice Form must cover the following columns as per the agreed ContractTariff List: 1. ***Service Description*** 2. ***Gross Price*** 3. ***Discount %*** 4. ***Net Price***	
18	**Batch of *Original* Claim Forms is Submitted as per the Contract Submission Period.**	

Name & Signature Of Billing person approving Final Check

Please include this Form with the *Detailed Statement of Account*

Appendix L – Provider General Information

General Information

Provider Name	Provider Type	City	Country	Full Address-Head Office (Street Name, Building, Flat #, Floor)

P.O.BOX	General Phone	General Fax	General Email	Website

Signatory Person Name	Signatory person Position	Signatory Person Mobile	Signatory Person Email

Account Name	Account Number	Swift Code	Bank Name	Bank Branch

Doctors and Specialities

#	Branch Name	Doctor's Name	Doctor's Specialty as per license	License Number	Contact Number	Nationality	Gender	Time Availability	Sub Speciality	Expiry date of license	Other facilities (if any) this doctor is practising In
1											
2											
3											
4											
5											
6											
7											
8											
9											
10											

Branches General Information

#	Branch Name	Branch Manager	Email/ Mobile / Direct Number / Fax	Insurance Contact Person	Email/ Mobile / Direct Number / Fax	Billing Contact Person	Email/ Mobile / Direct Number / Fax	Accounts Contact Person	Email/ Mobile / Direct Number / Fax	Customer service / Reception contact person	Email/ Mobile / Direct Number / Fax	Full Address (Street Name, Building, Flat #, Floor), City & Country	P.O. BOX	General Phone	General Fax	General Email
1																
2																
3																
4																
5																
6																
7																
8																
9																
10																