

Sample Claim Form No:

استمارة المطالبة

Please complete all the fields

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

Date: / /	Healthcare Provider:		
PATIENT INFORMATION			
Patient's Name (as on card):			<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.
Card #	Policy No.	Birth date: / /	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
		dd mm yy	
INFORMATION To be completed by Physician			
Date of present symptoms: / /	Symptom(s) as described by Patient:		
	dd	mm	yy
Pre-existing Condition(s) being treated for:	<input type="checkbox"/> No <input type="checkbox"/> Yes	If Yes _____	
Chronic Medications:	<input type="checkbox"/> No <input type="checkbox"/> Yes	Specify: _____	
Family History of any Illness:	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____	
OBJECTIVE / ASSESSMENT To be completed by Physician			
Clinical Findings:			
Cause <input type="checkbox"/> Physical Illness <input type="checkbox"/> Accident <input type="checkbox"/> Maternity <input type="checkbox"/> Preventive <input type="checkbox"/> Psychiatric <input type="checkbox"/> Dental <input type="checkbox"/> Work Related			
<input type="checkbox"/> Other(s), Explain			
Assessment/Diagnosis	<input type="checkbox"/> Acute	<input type="checkbox"/> Chronic	<input type="checkbox"/> Confirmed <input type="checkbox"/> Suspected
1-			
2-			
MEDICAL PLAN			
<i>Itemized Original Invoices & Applicable Prescriptions/ Reports/ Results must be enclosed to consider the claim</i>			
<input type="checkbox"/> Consultation <input type="checkbox"/> Physiotherapy <input type="checkbox"/> Laboratory <input type="checkbox"/> Radiology/Other <input type="checkbox"/> 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			
<i>Discharge summary, Itemized Invoices, Report, Results should be attached</i>			
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:		