UCAF 2.0

To be completed and ID verified by the reception/nurse:

Provider Name: Consultant Radiologists (Riyadh Scan)

Insurance Company Name: Malath

TPA Company Name:

Patient File Number:

Dept: Radiology Specialty

Single ( ) Married ( ) Plan Type ( )

Date of visit: 28/04/2025 08:14:00 PM

New visit ( ) Follow Up ( ) Refill ( ) Walk In ( ) Referral (✓)

Approval Date/Time: 28/04/2025 20:16:47

Approval Validity: 7 Days

Print/Fill in clear letters or Emboss Card:

Insured Name: hasan abdullah awadh abdullah

ID. Card No: 002303488437001 National ID: 2303488437

Sex: Male Age: 33 Year

Policy Holder: Precious Jewels Foundation for Precious Metals

Policy No: 24559892

Member Since: Member Type:

Expiry Date: 14/08/2025 12:00:00 AM Class: b3s

Approval Reference Number: 39542420

Approval Status: Approved Approval Type: Professional (OutPatient)

Message:

adjudication,Payer: Additional adjudication,Payer: THE REQUESTED SERVICE DOES NOT REQUIRE PRIOR APPROVAL. PLEASE FOLLOW CONTRACT TERMS, CONDITIONS AND EXCLUSIONS.,

To be Completed by the Attending PHYSICIAN: Please tick (✓)

Inpatient ( ) Outpatient (✓) **Emergency Case** ( ) | Emergency Case Level: 1 2 3 4 5

Physician Name [ID]: KHALED ALY

BP: - Pulse: Temp: 34.5 Weight: Height: R.R: Duration of Illness:

Chief Complaints and Main Symptoms: Dear dr ,,,ptn referred from another provider for ct scan

Siginficant Signs:

Possible Line of Treatment

Other Conditions:

Diagnosis

Principal Code: G44-Other headache syndromes **2nd Code:** **3rd Code:**

4th Code: **5th Code:** **6th Code:**

Please tick (✓) where appropriate:

Chronic ( ) Congenital ( ) RTA ( ) Work Related ( ) Vaccination ( )

Check-up ( ) Psychiatric ( ) Infertility ( ) Pregnancy ( ) Indicate LMP: ( )

Suggestive line(s) of management: Kindly, enumerate the recommended investigations, and/or procedures **For outpatient approvals only:**

(Code) Service	Type	Req. Qty	Req. Cost	Gross amount	App. Qty	App. Cost	App. Gross	Note
(56001-00-00) Computerised tomography of brain - (11001) CT Brain	Imaging services	1.0	287.50	250.00	1.0	287.5	287.50	Approved

Providers Approval/Coding Staff must review/code the recommended service(s) and allocate cost and complete the following:

Completed/Coded By. Signature ..... Date

Medication Name (Generic Name)	Type	Req. Qty	Req. Cost	Gross amount	App. Qty	App. Cost	App. Gross	Note
No Data To Be Shown								

In case Management Form (CMF1.0) included Yes ( ) No ( )

Please specify possible line of management when applicable:

Expected date of admission:

Estimated Cost: 287.50 (SAR) **Estimated Gross:** 250.00 (SAR) **Total Approved Cost:** 287.5 (SAR)

Estimated Length of stay: days

Approved Length of stay: days

Provider Comments:

I hereby certify that ALL information mentioned are correct and that the medical services shown on this form were medically indicated and necessary for the management of this case.

Physician .....

Signature ..... Date ...../...../.....

I hereby certify that ALL statements and information provided concerning patient identification and the present illness or injury are TRUE.

Name (and relationship if guardian): .....

Signature(*) Date ...../...../.....

For Insurance Comapny Use Only Approved (✓) Not Approved ( ) Approval No: 39542420 Approval validity: 7 Days

Comments (include approved days/services if different from the requested)

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Approved/Disapproved By ..... Signature ..... Date: ...../...../.....

(*) this is applicable only in case of manual UCAF