AL MADALLAH Form

almadallah Healthcare Management

Claim Form

استمـــارة المطالبة

Please complete all the fields

For Pre Approval kindly call our Help Line for 24 hours: 04 559 1322 Fax: +9714 434 2310

No:

Date:	26-Jun-2024	Healthcare Provider:	CITICARE MEDICAL CENTER LLC

PATIENT INFORMATION

Patient's Name (as on card)	Muhammed Ali Moozhikkal Ismayil Varuva Thodukayil	○ Mr. ○ Mrs. ○ Ms.			
Card #	Policy No.	Birth Date :	19-Apr-1997 (dd mm yy)	Sex:	Male
1688356					

INFORMATION

To be completed by Physician

Date of present symptoms:	26/06/2024 (dd mm yy)	Symptom(s) as described by Patient:

Complaint

co pusy nodules onthe leg 4 nodules with pus fever on and off itching 20 june 2024

oe pusy nodules 4 on the same leg left side

chest is clear no added sounds

restless can not walk properly

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

Date	CPT Code	Treatment	Qty	Unit Price
26-Jun-2024	96361	Intravenous infusion, hydration; each additional h (Co.Pay)	1	10.80
26-Jun-2024	96367	Intravenous infusion, for therapy, prophylaxis, or (Co.Pay)	1	22.50
26-Jun-2024	83037	Hemoglobin; glycosylated (A1C) by device cleared b (Lab)	1	18.90
26-Jun-2024	0102-111908-1001	SODIUM CHLORIDE B.P. (Pharmacy)	1	4.50
26-Jun-2024	96365	Intravenous infusion, for therapy, prophylaxis, or (Co.Pay)	1	46.80
26-Jun-2024	0148-116601-1001	METRONIDAZOLE-Amrizole (Pharmacy)	1	7.50
26-Jun-2024	0195-107704-0801	CEFTRIAXONE-TABUK IV (Pharmacy)	1	48.50
26-Jun-2024	87070	Culture, bacterial; any other source except urine, (Lab)	1	17.10
26-Jun-2024	86140	C-reactive protein; (Lab)	1	12.60
26-Jun-2024	85652	Sedimentation rate, erythrocyte; automated (Lab)	1	5.40
				239.90

Date	CPT Code	Treatment	Qty	Unit Price
26-Jun-2024	85025	Blood count; complete (CBC), automated (Hgb, Hct, **(Lab)**	1	**15.30**
26-Jun-2024	9	Consultation GP **(General Consultation)**	1	**30.00**
				239.90

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	26-Jun-2024	Humaira	R50.9	Fever, unspecified			Admitting Provider
Secondary	26-Jun-2024	Humaira	L29.9	Pruritus, unspecified			Admitting Provider
Secondary	26-Jun-2024	Humaira	L02.439	Carbuncle of limb, unspecified			Admitting Provider
Secondary	26-Jun-2024	Humaira	R52	Pain, unspecified			Admitting Provider

MEDICAL PLAN

Itemized Original Invoices & Applicable Prescriptions/Reports/Results must be enclosed to consider the claim

☐ Consultation	☐ Physiotherapy	☐ Laboratory	☐ Radiology/Other	☐ Pharmacy

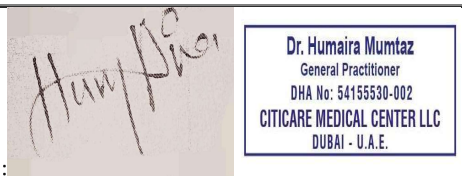
		For Almadallah's Use only
Pre-authorization Required for:		As per agreed tariff
Full details of proposed treatment/Surgery/Medicine:		Approval Code:

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: Humaira		**Patient/Guardian signature**	
Tel/Fax: 0524244416			
Signature & Stamp: 			
Date: 26-06-2024		Date: 26-06-2024	
Claims should be submitted with supporting documents within 30 days from date of service or as per contract.			