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:	29-Jun-2024	**Healthcare Provider:**	CITICARE MEDICAL CENTER LLC			
PATIENT INFORMATION						
Patient's Name (as on card)	NAVEEDA JAN MOHAMMAD ALTAF MIR MIR	○ Mr. ○ Mrs. ○ Ms.				
Card #	Policy No.	Birth Date :	28-Jul-1999	**Sex:**	Female	
784-1999-9577161-7			*dd mm yy*			
INFORMATION		***To be completed by Physician***				
Date of present symptoms:	29/06/2024 *dd mm yy*	Symptom(s) as described by Patient:				

Complaint

PC: High grade fever, frequency of urine and pain on passing urine.

Duration: 1 days

She is not a known hypertensive but BP is noticed to be elevated at presentation.

She is not a known diabetic and has no other medical condition of note.

Counselled on the need for weight reduction.

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
29-Jun-2024	96375	Therapeutic, prophylactic, or diagnostic injection **(Co.Pay)**	2	**10.80**
29-Jun-2024	96367	Intravenous infusion, for therapy, prophylaxis, or **(Co.Pay)**	1	**22.50**
29-Jun-2024	9	Consultation GP **(General Consultation)**	1	**30.00**
29-Jun-2024	0195-107704-0801	CEFTRIAXONE-TABUK IV-(CEFTRIAXONE : 1 G) POWDER F **(Pharmacy)**	1	**48.50**
29-Jun-2024	0005-150403-1021	PREMOSAN -(METOCLOPRAMIDE : 10 MG/2ML) SOLUTION F **(Pharmacy)**	1	**0.90**
29-Jun-2024	2190-106618-1001	PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) S **(Pharmacy)**	1	**8.40**
29-Jun-2024	96372	Therapeutic, prophylactic, or diagnostic injection **(Co.Pay)**	1	**9.00**
29-Jun-2024	0005-149902-1021	CLOFEN **(Pharmacy)**	1	**6.50**
29-Jun-2024	0005-242802-0781	PANTONIX 40MG I.V.-(PANTOPRAZOLE (AS SODIUM) : 40 **(Pharmacy)**	1	**29.50**
29-Jun-2024	96365	Intravenous infusion, for therapy, prophylaxis, or **(Co.Pay)**	1	**46.80**
29-Jun-2024	81001	Urinalysis, by dip stick or tablet reagent for bil **(Lab)**	1	**6.30**
29-Jun-2024	86140	C-reactive protein; **(Lab)**	1	**12.60**
29-Jun-2024	85025	Blood count; complete (CBC), automated (Hgb, Hct, **(Lab)**	1	**15.30**
				247.10

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	29-Jun-2024	Enomen Goodluck	N39.0	Urinary tract infection, site not specified			Admitting Provider
Secondary	29-Jun-2024	Enomen Goodluck	K29.00	Acute gastritis without bleeding			Admitting Provider
Secondary	29-Jun-2024	Enomen Goodluck	R50.9	Fever, unspecified			Admitting Provider
Secondary	29-Jun-2024	Enomen Goodluck	J06.9	Acute upper respiratory infection, unspecified			Admitting Provider
Secondary	29-Jun-2024	Enomen Goodluck	M54.5	Low back pain			Admitting Provider

MEDICAL PLAN

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

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

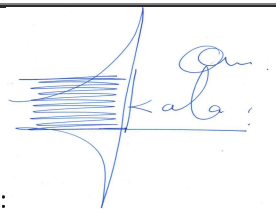
		For Almadallah's Use only
Pre-authorization Required for:		As per agreed tariff
Full details of proposed treatment/Surgery/Medicine:		Approval Code:

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: Enomen Goodluck		**Patient/Guardian signature**	
Tel/Fax: 1234567			
Signature & Stamp: 			

Date: 29-06-2024	Date: 29-06-2024
Claims should be submitted with supporting documents within 30 days from date of service or as per contract.	