AL MADALLAH Form

almadallah Healthcare Management

Claim Form

استمـــارة المطالبة

No:

Please complete all the fields

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

Date:	17-Jul-2024	**Healthcare Provider:**	CITICARE MEDICAL CENTER LLC

PATIENT INFORMATION

Patient's Name (as on card)	OMER ELBALULA ABDALLA DAFALLA	○ Mr. ○ Mrs. ○ Ms.			
Card #	Policy No.	Birth Date :	31-Jul-1988	**Sex:**	Male
784-1988-0939025-9			*dd mm yy*		

INFORMATION

To be completed by Physician

Date of present symptoms:	17/07/2024 *dd mm yy*	Symptom(s) as described by Patient:

Complaint

co fever high grade nausea headache bodyache left ear pain dark colour of urine 14th july 2024

oe

enlarge tonsillls ear mambrane is congested

chest is clear no nadded sounds

restlesss

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
17-Jul-2024	96367	Intravenous infusion, for therapy, prophylaxis, or **(Co.Pay)**	2	**22.50**
17-Jul-2024	9	Consultation GP **(General Consultation)**	1	**30.00**
17-Jul-2024	2190-106618-1001	PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) S **(Pharmacy)**	1	**8.40**
17-Jul-2024	96372	Therapeutic, prophylactic, or diagnostic injection **(Co.Pay)**	1	**9.00**
17-Jul-2024	96375	Therapeutic, prophylactic, or diagnostic injection **(Co.Pay)**	1	**10.80**
17-Jul-2024	96365	Intravenous infusion, for therapy, prophylaxis, or **(Co.Pay)**	1	**46.80**
17-Jul-2024	0005-150403-1021	PREMOSAN -(METOCLOPRAMIDE : 10 MG/2ML) SOLUTION F **(Pharmacy)**	1	**0.90**
17-Jul-2024	0005-149902-1021	CLOFEN -(DICLOFENAC SODIUM : 75 MG/3ML) SOLUTION **(Pharmacy)**	1	**6.50**
17-Jul-2024	0248-187801-1171	METRONIDAZOLE, DILOXANIDE FUROATE-Furazol **(Pharmacy)**	1	**11.50**
				244.50

Date	CPT Code	Treatment	Qty	Unit Price
17-Jul-2024	0005-107704-0802	TRIAXONE I.V.-(CEFTRIAXONE : 1 G) POWDER FOR INJE **(Pharmacy)**	1	**58.50**
17-Jul-2024	81001	Urinalysis, by dip stick or tablet reagent for bil **(Lab)**	1	**6.30**
17-Jul-2024	85652	Sedimentation rate, erythrocyte; automated **(Lab)**	1	**5.40**
17-Jul-2024	86140	C-reactive protein; **(Lab)**	1	**12.60**
17-Jul-2024	85025	Blood count; complete (CBC), automated (Hgb, Hct, **(Lab)**	1	**15.30**
				244.50

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	17-Jul-2024	Humaira	R50.9	Fever, unspecified			Admitting Provider
Secondary	17-Jul-2024	Humaira	H66.92	Otitis media, unspecified, left ear			Admitting Provider
Secondary	17-Jul-2024	Humaira	R52	Pain, unspecified			Admitting Provider
Secondary	17-Jul-2024	Humaira	K29.00	Acute gastritis without bleeding			Admitting Provider
Secondary	17-Jul-2024	Humaira	N39.0	Urinary tract infection, site not specified			Admitting Provider

MEDICAL PLAN

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

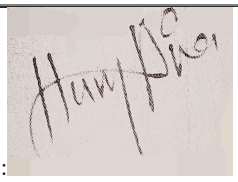
☐ **Consultation**	☐ **Physiotherapy**		☐ **Laboratory**	☐ **Radiology/Other**	☐ **Pharmacy**
				For Almadallah's Use only
Pre-authorization Required for:				As per agreed tariff
Full details of proposed treatment/Surgery/Medicine:				Approval Code:

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:  Dr. Humaira Mumtaz General Practitioner DHA No: 54155530-002 CITICARE MEDICAL CENTER LLC DUBAI - U.A.E.		
Date: 17-07-2024	Date: 17-07-2024	

Claims should be submitted with supporting documents within 30 days from date of service or as per contract.