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:	21-Jul-2024	**Healthcare Provider:**	CITICARE MEDICAL CENTER LLC				
PATIENT INFORMATION							
Patient's Name (as on card)	PRISCILLA ROSE BALDAZO PASTRANA	○ Mr. ○ Mrs. ○ Ms.					
Card #	Policy No.	Birth Date :	14-Nov-1995	**Sex:**	Female		
784-1995-9007194-2			*dd mm yy*				
INFORMATION		***To be completed by Physician***					
Date of present symptoms:	21/07/2024 *dd mm yy*	Symptom(s) as described by Patient:					

Complaint

PC: SORE THROAT 1 DAY

FEVER 1 DAY

COUGH 1 DAY

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
21-Jul-2024	9	Consultation GP **(General Consultation)**	1	**30.00**
21-Jul-2024	0125-122107-1022	DEXAMETHASONE SODIUM PHOSPHATE **(Pharmacy)**	1	**2.34**
21-Jul-2024	96372	Therapeutic, prophylactic, or diagnostic injection **(Co.Pay)**	1	**9.00**
21-Jul-2024	9	Consultation Gp **(General Consultation)**	1	**60.00**
21-Jul-2024	96372	Therapeutic, Prophylactic, Or Diagnostic Injection **(Co.Pay)**	1	**19.00**
21-Jul-2024	0125-122107-1022	DEXAMETHASONE SODIUM PHOSPHATE-(DEXAMETHASONE : 4 **(Pharmacy)**	1	**2.34**
				122.68

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	21-Jul-2024	Enomen Goodluck	R50.9	Fever, unspecified			Admitting Provider
Secondary	21-Jul-2024	Enomen Goodluck	J06.9	Acute upper respiratory infection, unspecified			Admitting Provider
Secondary	21-Jul-2024	Enomen Goodluck	J00	Acute nasopharyngitis [common cold]			Admitting Provider

MEDICAL PLAN

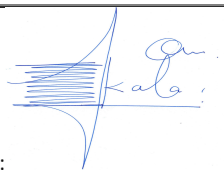
Itemized Original Invoices & Applicable Prescriptions/Reports/Results must be enclosed to consider the claim

☐ **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: 21-07-2024	Date: 21-07-2024		
Claims should be submitted with supporting documents within 30 days from date of service or as per contract.			