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-Aug-2024	**Healthcare Provider:**	CITICARE MEDICAL CENTER LLC				
PATIENT INFORMATION							
Patient's Name (as on card)	Emar Yaser Hasan		○ Mr. ○ Mrs. ○ Ms.				
Card #	Policy No.		Birth Date :	13-Feb-1994	**Sex:**	Male	
784-1994-7009403-0				*dd mm yy*			
INFORMATION			***To be completed by Physician***				
Date of present symptoms:	26/08/2024 *dd mm yy*	Symptom(s) as described by Patient:					

Complaint

Injury to the ring finger of left hand.

Duration: 20mins.

Sustained the injury during a gym session.

Exam: ragged laceration of the distal phalanx of the ring finger of left hand.

measuring 8cm in lenth

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-Aug-2024	9	Consultation GP **(General Consultation)**	1	**30.00**
26-Aug-2024	86774	Antibody; tetanus **(Lab)**	1	**27.90**
26-Aug-2024	96372	Therapeutic, prophylactic, or diagnostic injection **(Co.Pay)**	1	**9.00**
26-Aug-2024	0005-149902-1021	CLOFEN **(Pharmacy)**	1	**6.50**
26-Aug-2024	0102-111908-1001	SODIUM CHLORIDE B.P.-(SODIUM CHLORIDE : 0.9% W/V) **(Pharmacy)**	2	**4.50**
26-Aug-2024	96360	Intravenous infusion, hydration; initial, 31 minut **(Co.Pay)**	1	**32.40**
				110.30

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-Aug-2024	Enomen Goodluck	S61.210A	Laceration w/o fb of r idx fngr w/o damage to nail, init			Admitting Provider
Secondary	26-Aug-2024	Enomen Goodluck	G89.11	Acute pain due to trauma			Admitting Provider

MEDICAL PLAN

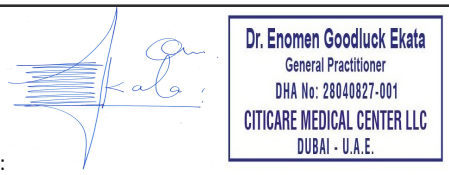
Itemized Original Invoices & Applicable Prescriptions/Reports/Results must be enclosed to consider the claim

☐ **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: 26-08-2024	Date: 26-08-2024		

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