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:	27-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 *dd mm yy*	**Sex:**	Male		
784-1994-7009403-0							
INFORMATION		***To be completed by Physician***					
Date of present symptoms:	27/08/2024 *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
27-Aug-2024	99211	Office or other outpatient visit for the evaluatio **(Co.Pay)**	1	**17.10**
27-Aug-2024	0195-107704-0801	CEFTRIAXONE-TABUK IV-(CEFTRIAXONE : 1 G) POWDER F **(Pharmacy)**	5	**48.50**
27-Aug-2024	0002-116601-1001	METRONIDAZOLE-Metronidazole **(Pharmacy)**	5	**8.00**
27-Aug-2024	9.01	Follow Up - Consultation GP **(General Consultation)**	1	**0.00**
				73.60

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	27-Aug-2024	Enomen Goodluck	S61.210A	Laceration w/o fb of r idx fngr w/o damage to nail, init			Admitting Provider

Type	Date	Doctor	ICD Code	Diagnosis	Notes	year	Problem Role
Secondary	27-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

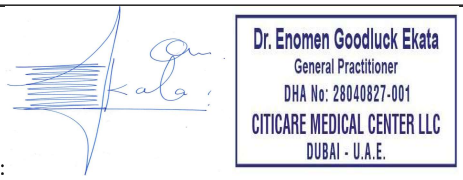
		For Almadallah's Use only
Pre-authorization Required for:		As per agreed tariff
Full details of proposed treatment/Surgery/Medicine:		Approval Code:

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: 27-08-2024		Date: 27-08-2024	

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