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:	09-Sep-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:	09/09/2024 dd mm yy	Symptom(s) as described by Patient:					

Complaint

For follow up and change of wound dressing

Nil complaint

Wound is healing satisfactorily

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
09-Sep-2024	9.01	Follow Up - Consultation GP (General Consultation)	1	0.00
09-Sep-2024	51.01	Non-surgical cleansing of a wound without debridem (General Consultation)	1	13.50
				13.50

Cause	☐ Physical Illness	☐ Accident	☐ Maternity	☐ Preventive	☐ Psychiatric	☐ Dental	☐ Work Related
☐ Other(s) Explain							

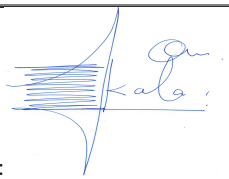
Assessment/ Diagnosis	☐ Acute	☐ Chronic	☐ Confirmed	☐ Suspected

Type	Date	Doctor	ICD Code	Diagnosis	Notes	year	Problem Role
Primary	09-Sep-2024	Enomen Goodluck	S61.210D	Laceration w/o fb of r idx fngr w/o damage to nail, subs			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: 09-09-2024		Date: 09-09-2024	
Claims should be submitted with supporting documents within 30 days from date of service or as per contract.			