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:	10-Sep-2024	Healthcare Provider:	CITICARE MEDICAL CENTER LLC			
PATIENT INFORMATION						
Patient's Name (as on card)	MARGARET WANJIRU	○ Mr. ○ Mrs. ○ Ms.				
Card #	Policy No.	Birth Date :	13-Jul-1990 dd mm yy	Sex:	Female	
1566184						
INFORMATION		To be completed by Physician				
Date of present symptoms:	10/09/2024 dd mm yy	Symptom(s) as described by Patient:				

Complaint

PC: ASTHMATIC PEVIOUSLY

ANAL FISSURE

HEADACHE LIKE MIGRAINE

DERMATITIS

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
10-Sep-2024	9	Consultation Gp (General Consultation)	1	60.00
				60.00

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	10-Sep-2024	AHSAN HUSSAIN	J45.20	Mild intermittent asthma, uncomplicated			Admitting Provider
Secondary	10-Sep-2024	AHSAN HUSSAIN	K60.2	Anal fissure, unspecified			Admitting Provider
Secondary	10-Sep-2024	AHSAN HUSSAIN	G43.D0	Abdominal migraine, not intractable			Admitting Provider
Secondary	10-Sep-2024	AHSAN HUSSAIN	L40.9	Psoriasis, unspecified			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: ALMadallah GN+ GN RN GOVT POLICE DEWA**	**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: AHSAN HUSSAIN		**Patient/Guardian signature**	

Tel/Fax: 0521644729	
Signature & Stamp: 	
Date: 10-09-2024	Date: 10-09-2024
Claims should be submitted with supporting documents within 30 days from date of service or as per contract.	