



Claim Form

استمارة المطالبة

No:

Please complete all the fields
For Pre Approval kindly call our Help Line for 24 hours: 04 559 1322 Fax: +9714 434 2310

Date:	10-Sep-2024	Healthcare Provider:	CITICARE MEDICAL CENTER LLC		
PATIENT INFORMATION					
Patient's Name (as on card)	DIEGO ALEXANDER ARIAS DUQUE		☐ Mr. ☐ Mrs. ☐ Ms.		
Card #	Policy No.	Birth Date :	21-Jan-1992	Sex:	Male
784-1992-4154790-2			dd mm yy		
INFORMATION			<i>To be completed by Physician</i>		
Date of present symptoms:	10/09/2024	Symptom(s) as described by Patient:			
	dd mm yy				
Complaint					
co constipation lower abdominal pain dark colour of urine dribbling of urine 3rd sep. 2024 oe lower abdominal pain chest is clear no added sounds restless					
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			<i>To be completed by Physician</i>		
Clinical Finding					
Date	CPT Code	Treatment	Qty	Unit Price	
10-Sep-2024	96361	Intravenous infusion, hydration; each additional h (Co.Pay)	1	12.60	
10-Sep-2024	85025	Blood count; complete (CBC), automated (Hgb, Hct, (Lab)	1	18.00	
10-Sep-2024	0005-149902-1021	CLOFEN -(DICLOFENAC SODIUM : 75 MG/3ML) SOLUTION (Pharmacy)	1	6.50	
10-Sep-2024	86140	C-reactive protein; (Lab)	1	17.10	
10-Sep-2024	96372	Therapeutic, prophylactic, or diagnostic injection (Co.Pay)	1	10.80	
10-Sep-2024	96365	Intravenous infusion, for therapy, prophylaxis, or (Co.Pay)	1	54.00	
10-Sep-2024	0102-152902-1001	LACTATED RINGERS INJECTION USP-(CALCIUM CHLORIDE : (Pharmacy)	1	5.00	
10-Sep-2024	0002-116601-1001	METRONIDAZOLE-Metronidazole (Pharmacy)	1	8.00	
10-Sep-2024	81001	Urinalysis, by dip stick or tablet reagent for bil (Lab)	1	6.30	
10-Sep-2024	85652	Sedimentation rate, erythrocyte; automated (Lab)	1	5.40	
				208.70	

Date	CPT Code	Treatment	Qty	Unit Price
10-Sep-2024	9	Consultation GP (General Consultation)	1	35.00
10-Sep-2024	9	Consultation GP (General Consultation)	1	30.00
				208.70

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	Humaira	R50.9	Fever, unspecified			Admitting Provider
Secondary	10-Sep-2024	Humaira	N39.0	Urinary tract infection, site not specified			Admitting Provider
Secondary	10-Sep-2024	Humaira	K56.41	Fecal impaction			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:		

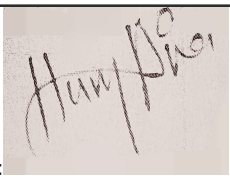
IN-PATIENT
Discharge summary, Itemized Invoices, Report, Results should be attached

Length of stay:	Provider: AL MADALLAH RN3	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: Humaira	Patient/Guardian signature	
----------------------------------	----------------------------	---

Tel/Fax: 0524244416	
---------------------	--

 Signature & Stamp:	 Dr. Humaira Mumtaz General Practitioner DHA No: 54155530-002 CITICARE MEDICAL CENTER LLC DUBAI - U.A.E.
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.