AL MADALLAH Form

almadallah Healthcare Management

Claim Form

استمـــارة 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:	11-Sep-2024	**Healthcare Provider:**	CITICARE MEDICAL CENTER LLC

PATIENT INFORMATION

Patient's Name (as on card)	Mirella Alkhoury	○ Mr. ○ Mrs. ○ Ms.		
Card #	Policy No.	Birth Date :	03-Jan-1998	**Sex:**
784-1998-8624702-4			*dd mm yy*	

INFORMATION

To be completed by Physician

Date of present symptoms:	11/09/2024 *dd mm yy*	Symptom(s) as described by Patient:

Complaint

CO FEVER on and off dry cough running nose 3rd sep. 2024

oe

enlarge tonsills

chest is congested no added sounds

restless

t

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
11-Sep-2024	96367	Intravenous infusion, for therapy, prophylaxis, or **(Co.Pay)**
11-Sep-2024	96365	Intravenous infusion, for therapy, prophylaxis, or **(Co.Pay)**
11-Sep-2024	96372	Therapeutic, prophylactic, or diagnostic injection **(Co.Pay)**

Date	CPT Code	Treatment
11-Sep-2024	0195-107704-0801	CEFTRIAXONE-TABUK IV **(Pharmacy)**
11-Sep-2024	0005-149902-1021	CLOFEN -(DICLOFENAC SODIUM : 75 MG/3ML) SOLUTION **(Pharmacy)**
11-Sep-2024	2190-106618-1001	PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) S **(Pharmacy)**
11-Sep-2024	85652	Sedimentation rate, erythrocyte; automated **(Lab)**
11-Sep-2024	86140	C-reactive protein; **(Lab)**
11-Sep-2024	85025	Blood count; complete (CBC), automated (Hgb, Hct, **(Lab)**
11-Sep-2024	9	Consultation GP **(General Consultation)**

Cause	☐ Physical Illness	☐ Accident	☐ Maternity	☐ Preventive	☐ Psychiatric	☐ Denta
☐ Other(s) Explain						

Assessment/ Diagnosis	☐ Acute	☐ Chronic	☐ Confirme

Type	Date	Doctor	ICD Code	Diagnosis	Notes
Primary	11-Sep-2024	Humaira	R50.9	Fever, unspecified	
Secondary	11-Sep-2024	Humaira	J06.9	Acute upper respiratory infection, unspecified	
Secondary	11-Sep-2024	Humaira	R05	Cough	
Secondary	11-Sep-2024	Humaira	K29.00	Acute gastritis without bleeding	
Secondary	11-Sep-2024	Humaira	J30.9	Allergic rhinitis, unspecified	

MEDICAL PLAN

Itemized Original Invoices & Applicable Prescriptions/Reports/Results must be enclosed to consid

☐ Consultation	☐ Physiotherapy	☐ Laboratory	☐ Radiology/Other
			For Almadallah's U
Pre-authorization Required for:			As per agreed tariff
Full details of proposed treatment/Surgery/Medicine:			Approval Code:

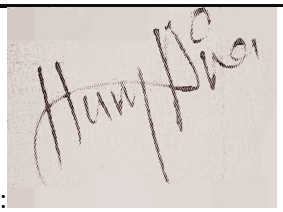
IN-PATIENT

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 ot 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: 11-09-2024	Date: 11-09-2024
Claims should be submitted with supporting documents within 30 days from date of service or as per contract.	