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:	12-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:	Female	
784-1998-8624702-4			dd mm yy			
INFORMATION		*To be completed by Physician*				
Date of present symptoms:	12/09/2024 dd mm yy	Symptom(s) as described by Patient:				
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
12-Sep-2024	94640	Pressurized or nonpressurized inhalation treatment **(Co.Pay)**	1	**16.20**
12-Sep-2024	0188-135906-2441	PULMICORT-(BUDESONIDE : 0.5 MG/ML) SUSPENSION FOR **(Pharmacy)**	1	**10.48**
12-Sep-2024	96365	Intravenous infusion, for therapy, prophylaxis, or **(Co.Pay)**	1	**54.00**
12-Sep-2024	0195-107704-0801	CEFTRIAXONE-TABUK IV **(Pharmacy)**	1	**48.50**
12-Sep-2024	9.01	Follow Up - Consultation GP **(General Consultation)**	1	**0.00**
				129.18

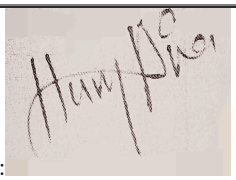
Cause	☐ Physical Illness	☐ Accident	☐ Maternity	☐ Preventive	☐ Psychiatric	☐ Dental	☐ Work Related
☐ Other(s) Explain							
Assessment/ Diagnosis				☐ Acute	☐ Chronic	☐ Confirmed	☐ Suspected

Type	Date	Doctor	ICD Code	Diagnosis	Notes	year	Problem Role
Primary	12-Sep-2024	Humaira	R50.9	Fever, unspecified			Admitting Provider
Secondary	12-Sep-2024	Humaira	J06.9	Acute upper respiratory infection, unspecified			Admitting Provider
Secondary	12-Sep-2024	Humaira	R05	Cough			Admitting Provider
Secondary	12-Sep-2024	Humaira	K29.00	Acute gastritis without bleeding			Admitting Provider
Secondary	12-Sep-2024	Humaira	J30.9	Allergic rhinitis, 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: 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:  			
Date: 12-09-2024		Date: 12-09-2024	
Claims should be submitted with supporting documents within 30 days from date of service or as per contract.			