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)	MUHAMMAD ADNAN FAZAL REHMAN	○ Mr. ○ Mrs. ○ Ms.					
Card #	Policy No.	Birth Date :	01-Jan-1988	Sex:	Male		
784-1987-0462425-7	IM237EA NLSB		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:					

Complaint

PC: Upper abdominal pain, chest pain, belching, fast breathing, and breathlessness.

Has headache, flu symptoms, nose block but no fever.

Duration: 3days.

Exam findings:

BP: 151/90mmhg,

RR = 36cpm, PR = 100bpm,

Chest is clinically clear with vesicular breath sounds, HS = S1, S2 only, nil murmur, nil thrills.

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	96375	Therapeutic, prophylactic, or diagnostic injection **(Co.Pay)**	2	**10.80**
12-Sep-2024	9	Consultation GP **(General Consultation)**	1	**30.00**
12-Sep-2024	96367	Intravenous infusion, for therapy, prophylaxis, or **(Co.Pay)**	1	**22.50**
12-Sep-2024	0125-122107-1022	DEXAMETHASONE SODIUM PHOSPHATE-(DEXAMETHASONE : 4 **(Pharmacy)**	1	**2.34**
12-Sep-2024	96372	Therapeutic, prophylactic, or diagnostic injection **(Co.Pay)**	1	**9.00**
12-Sep-2024	0005-149902-1021	CLOFEN **(Pharmacy)**	1	**6.50**
12-Sep-2024	2190-106618-1001	PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) S **(Pharmacy)**	1	**8.40**
				301.32

Date	CPT Code	Treatment	Qty	Unit Price
12-Sep-2024	0005-174202-0781	RISEK 40MG (Pharmacy)	1	34.00
12-Sep-2024	0188-135906-2441	PULMICORT (Pharmacy)	1	10.48
12-Sep-2024	94640	Pressurized or nonpressurized inhalation treatment (Co.Pay)	1	14.40
12-Sep-2024	0195-107704-0801	CEFTRIAXONE-TABUK IV (Pharmacy)	2	48.50
12-Sep-2024	96365	Intravenous infusion, for therapy, prophylaxis, or (Co.Pay)	1	46.80
12-Sep-2024	93000	Electrocardiogram, routine ECG with at least 12 le (Co.Pay)	1	29.70
12-Sep-2024	86140	C-reactive protein; (Lab)	1	12.60
12-Sep-2024	85025	Blood count; complete (CBC), automated (Hgb, Hct, (Lab)	1	15.30
				301.32

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	Enomen Goodluck	R07.9	Chest pain, unspecified			Admitting Provider
Secondary	12-Sep-2024	Enomen Goodluck	J22	Unspecified acute lower respiratory infection			Admitting Provider
Secondary	12-Sep-2024	Enomen Goodluck	J01.40	Acute pansinusitis, unspecified			Admitting Provider
Secondary	12-Sep-2024	Enomen Goodluck	R06.00	Dyspnea, unspecified			Admitting Provider
Secondary	12-Sep-2024	Enomen Goodluck	R00.2	Palpitations			Admitting Provider
Secondary	12-Sep-2024	Enomen Goodluck	R50.9	Fever, unspecified			Admitting Provider
Secondary	12-Sep-2024	Enomen Goodluck	E86.0	Dehydration			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:	

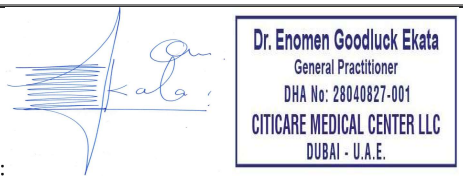
IN-PATIENT

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: 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.	