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:	14-Sep-2024	**Healthcare Provider:**	CITICARE MEDICAL CENTER LLC			
PATIENT INFORMATION						
Patient's Name (as on card)	ADNAN SAQIB MUHAMMAD ABDUL QADIR KHAN	○ Mr. ○ Mrs. ○ Ms.				
Card #	Policy No.	Birth Date :	12-Apr-1979 *dd mm yy*	**Sex:**	Male	
784-1979-5215815-8						
INFORMATION		***To be completed by Physician***				
Date of present symptoms:	14/09/2024 *dd mm yy*	Symptom(s) as described by Patient:				

Complaint

PC: FEVER

VOMITING

EPIGASTRIC PAIN

COUGH

COLD

HEADACHE

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
14-Sep-2024	9	Consultation GP **(General Consultation)**	1	**30.00**
14-Sep-2024	96367	Intravenous infusion, for therapy, prophylaxis, or **(Co.Pay)**	4	**22.50**
14-Sep-2024	0005-149902-1021	CLOFEN -(DICLOFENAC SODIUM : 75 MG/3ML) SOLUTION **(Pharmacy)**	1	**6.50**
14-Sep-2024	0002-116601-1001	METRONIDAZOLE-Metronidazole **(Pharmacy)**	1	**8.00**
14-Sep-2024	86677	Antibody; Helicobacter pylori **(Lab)**	1	**28.80**
14-Sep-2024	86140	C-reactive protein; **(Lab)**	1	**12.60**
14-Sep-2024	85025	Blood count; complete (CBC), automated (Hgb, Hct, **(Lab)**	1	**15.30**
14-Sep-2024	96372	Therapeutic, prophylactic, or diagnostic injection **(Co.Pay)**	3	**9.00**
				314.44

Date	CPT Code	Treatment	Qty	Unit Price
14-Sep-2024	96365	Intravenous infusion, for therapy, prophylaxis, or (Co.Pay)	1	46.80
14-Sep-2024	0005-136504-1021	SCOPINAL (Pharmacy)	1	4.60
14-Sep-2024	0005-174202-0781	RISEK 40MG (Pharmacy)	1	34.00
14-Sep-2024	0046-150403-1021	METOCLOPRAMIDE-Clopram (Pharmacy)	1	3.50
14-Sep-2024	0125-122107-1022	DEXAMETHASONE SODIUM PHOSPHATE (Pharmacy)	1	2.34
14-Sep-2024	0195-107704-0801	CEFTRIAXONE SODIUM-Ceftriaxone-Tabuk (Pharmacy)	1	48.50
14-Sep-2024	2190-106618-1002	PARACETAMOL-Parafusiv (Pharmacy)	1	42.00
				314.44

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	14-Sep-2024	AHSAN HUSSAIN	K29.00	Acute gastritis without bleeding			Admitting Provider
Secondary	14-Sep-2024	AHSAN HUSSAIN	J06.9	Acute upper respiratory infection, unspecified			Admitting Provider
Secondary	14-Sep-2024	AHSAN HUSSAIN	J00	Acute nasopharyngitis [common cold]			Admitting Provider
Secondary	14-Sep-2024	AHSAN HUSSAIN	R10.13	Epigastric pain			Admitting Provider
Secondary	14-Sep-2024	AHSAN HUSSAIN	R11.2	Nausea with vomiting, unspecified			Admitting Provider

MEDICAL PLAN

Itemized Original Invoices & Applicable Prescriptions/Reports/Results must be enclosed to consider the claim

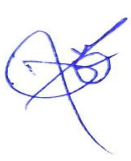
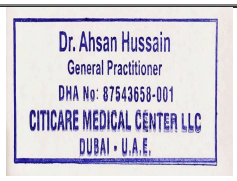
☐ Consultation	☐ Physiotherapy	☐ Laboratory	☐ Radiology/Other	☐ Pharmacy
			For Almadallah's Use only	
Pre-authorization Required for:			As per agreed tariff	
Full details of proposed treatment/Surgery/Medicine:			Approval Code:	

IN-PATIENT

Discharge summary, Itemized Invoices, Report, Results should be attached

Length of stay:	Provider: AL MADALLAH 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: AHSAN HUSSAIN		Patient/Guardian signature	
Tel/Fax: 0521644729			
Signature & Stamp:  		
Date: 14-09-2024		Date: 14-09-2024	
Claims should be submitted with supporting documents within 30 days from date of service or as per contract.			