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:	18-Sep-2024	Healthcare Provider:	CITICARE MEDICAL CENTER LLC

PATIENT INFORMATION

Patient's Name (as on card)	SALLY TAREK SAEID ABDALLAH	○ Mr. ○ Mrs. ○ Ms.			
Card #	Policy No.	Birth Date :	01-Jul-1987 (dd mm yy)	Sex:	Female
784-1987-2653532-5					

INFORMATION

To be completed by Physician

Date of present symptoms:	18/09/2024 (dd mm yy)	Symptom(s) as described by Patient:

Complaint

co fever on and off taking penadol at home nasal blokage dry cough 15th sep. 2024

oe

enlarge tonsills

chest is congested 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

To be completed by Physician

Clinical Finding

Date	CPT Code	Treatment	Qty	Unit Price
18-Sep-2024	94640	Pressurized or nonpressurized inhalation treatment **(Co.Pay)**	1	**14.40**
18-Sep-2024	0188-135906-2441	PULMICORT **(Pharmacy)**	1	**10.48**
18-Sep-2024	96372	Therapeutic, prophylactic, or diagnostic injection **(Co.Pay)**	1	**9.00**
18-Sep-2024	0005-149902-1021	CLOFEN **(Pharmacy)**	1	**6.50**
18-Sep-2024	96365	Intravenous infusion, for therapy, prophylaxis, or **(Co.Pay)**	1	**46.80**
18-Sep-2024	0195-107704-0801	CEFTRIAXONE-TABUK IV **(Pharmacy)**	1	**48.50**
18-Sep-2024	86140	C-reactive protein; **(Lab)**	1	**12.60**
18-Sep-2024	85025	Blood count; complete (CBC), automated (Hgb, Hct, **(Lab)**	1	**15.30**
18-Sep-2024	9	Consultation GP **(General Consultation)**	1	**30.00**
				193.58

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	18-Sep-2024	Humaira	J06.9	Acute upper respiratory infection, unspecified			Admitting Provider
Secondary	18-Sep-2024	Humaira	R05	Cough			Admitting Provider
Secondary	18-Sep-2024	Humaira	R50.9	Fever, unspecified			Admitting Provider
Secondary	18-Sep-2024	Humaira	K29.00	Acute gastritis without bleeding			Admitting Provider
Secondary	18-Sep-2024	Humaira	J03.90	Acute tonsillitis, unspecified			Admitting Provider

MEDICAL PLAN

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

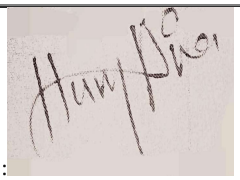
☐ Consultation	☐ Physiotherapy	☐ Laboratory	☐ Radiology/Other	☐ Pharmacy
			For Almadallah's Use only	
Pre-authorization Required for:			As per agreed tariff	
Full details of proposed treatment/Surgery/Medicine:			Approval Code:	

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: 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: 18-09-2024	Date: 18-09-2024		

Claims should be submitted with supporting documents within 30 days from date of service or as per contract.