AL MADALLAH Form





No

Please complete all the fields
For Pre Approval kindly call our Help Line for 24 hours: 04 559 1322 Fax: +9714 434 2310

M237EA NLSB M237EA NLSB M24 mm yy	Date: 20	0-Sep-2024	Healthcare P	rovider:		CITICARE MEDICAL	L CENTER LLC		
Card # Policy No. Policy No. Birth Date : Birth Date : Jan-1988 dd mm yy Sex	PATIENT	INFORMATION	ON						
Policy No. Jan-1988 Jan-198	Patient's N	Name (as on card)	MUHAMMAD) ADNAN FAZAL	REHMAN	OMr. OMrs. OMs.			
IM237EA NLSB	Card #		Policy No.			Birth Date : Jan-198		–Sex:	
Date of present symptoms: 20/09/2024 dd mm yy	784-1987	-0462425-7	IM237EA NL	SB					
Complaint Conjoint pain bodyache pallor 17th sep . 2024 oe joint pain chest is clear no added sounds restless Pre-existing Condition(s) being treated for : Chronic Medications: Family History of any Illness ONO Yes ONO Yes Family History of Expective Assessment Clinical Finding Date CPT Code Treatment Rheumatoid factor; quantitative (Lab) 20-Sep-2024 84550 Uric acid; blood (Lab) 20-Sep-2024 9 Consultation GP (General Consultation) Preventive Psychiatrid	INFORM	IATION				To be completed by Physician			
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Psychiatric Psychiatric	20-Sep-2	2024 9							
Psychiatric Psychiatric									
Other(s) Explain	Cause	Physical Illness	Accident		☐ Maternity	☐ Preventive	☐ Psychiatri	Dent	
I	Other(s) Explain							

1 of 2

Assessment/ Dia	gnosis				☐ Acute	Chronic	Confirme
Туре	Date	Doctor	ICD Code	Diagnosi	is	Notes	year
Primary	20-Sep-2024	Humaira	M62.838	Other m	uscle spasm		
Secondary	20-Sep-2024	Humaira	R52	Pain, unspecified			
_	inal Invoices &	& Applicable Preso	criptions/	Reports/F	1		
Consultation	<u> </u>	Physiotherapy			■ Laboratory		logy/Othe
Pre-authorization	Poquired for:						adallah's Ureed tariff
	•	C					
-uii details of pro	posed treatment/s	Surgery/Medicine:				Approval	Code:
IN-PATIENT							
	arv. Itemized Invoi	ices, Report, Results sh	ould be atta	ched			
Length of stay:	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	,,,			Provider: AL MAD	ALLAH RN4	Cost:
The above inform	ation is true to the	e best of my knowledge	e. I hereby a	uthorize any	Healthcare Provide	r, Insurer, Emp	oloyer or o
any information r	egarding my medi	cal conditions & history	to ALMADA	ALLAH for the	e purpose of deterr	nining insuran	ce benefit
Treating Physicia	n Name: Humaira					Patient/0 signature	
Tel/Fax: 0524244	416						
	Hant	Dr. Humaira M General Practiti DHA No: 541555	oner 30-002				
Signatura 9 Starra		CITICARE MEDICAL C Dubai - U.A.					
Signature & Stam Date: 20-09-2024	p:	CITICARE MEDICAL C Dubai - U.A.			Date: 20-09-2024		

2 of 2