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

PATIENT INFORMATION

Patient's Name (as on card)	SHANNON MIRANDA JOAQUIM MARIANO MIRANDA	○ Mr. ○ Mrs. ○ Ms.		
Card #	Policy No.	Birth Date :	22-Oct-1994	Sex:
784-1994-3949087-3			dd mm yy	

INFORMATION

To be completed by Physician

Date of present symptoms:	26/09/2024 dd mm yy	Symptom(s) as described by Patient:

Complaint

co back pain due to fall in the wash room 23rd sep. 2024

oe

muscle pain

chest is clear 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
26-Sep-2024	9	Consultation GP **(General Consultation)**
26-Sep-2024	96372	Therapeutic, prophylactic, or diagnostic injection **(Co.Pay)**
26-Sep-2024	96360	Intravenous infusion, hydration; initial, 31 minut **(Co.Pay)**
26-Sep-2024	0102-100104-1001	SODIUM CHLORIDE & DEXTROSE B.P. **(Pharmacy)**

Date	CPT Code	Treatment
26-Sep-2024	0005-149902-1021	CLOFEN -(DICLOFENAC SODIUM : 75 MG/3ML) SOLUTION **(Pharmacy)**

Cause	☐ Physical Illness	☐ Accident	☐ Maternity	☐ Preventive	☐ Psychiatric	☐ Denta
☐ Other(s) Explain						

Assessment/ Diagnosis	☐ Acute	☐ Chronic	☐ Confirme

Type	Date	Doctor	ICD Code	Diagnosis	Notes	year
Primary	26-Sep-2024	Humaira	M62.830	Muscle spasm of back		
Secondary	26-Sep-2024	Humaira	R52	Pain, unspecified		
Secondary	26-Sep-2024	Humaira	E86.0	Dehydration		

MEDICAL PLAN

Itemized Original Invoices & Applicable Prescriptions/Reports/Results must be enclosed to consid

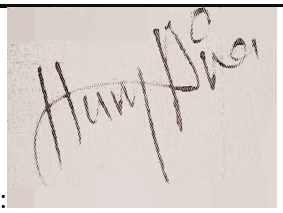
☐ Consultation	☐ Physiotherapy	☐ Laboratory	☐ Radiology/Other
			For Almadallah's U
Pre-authorization Required for:			As per agreed tariff
Full details of proposed treatment/Surgery/Medicine:			Approval Code:

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 ot 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: 26-09-2024		Date: 26-09-2024

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