

AL MADALLAH Form



Claim Form

استمارة المطالبة

No:

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

Date:	05-Oct-2024	Healthcare Provider:	CITICARE MEDICAL CENTER LLC		
PATIENT INFORMATION					
Patient's Name (as on card)	MOHAMMED FAISAL		☐ Mr. ☐ Mrs. ☐ Ms.		
Card #	Policy No.	Birth Date :	01-Jan-2000	Sex:	Male
784-2000-7160431-6			dd mm yy		
INFORMATION			<i>To be completed by Physician</i>		
Date of present symptoms:	05/10/2024	Symptom(s) as described by Patient:			
	dd mm yy				
Complaint					
COweakness dark colour urine abdominal pain fever on And off 27th sep. 2024 oe epigastric 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			<i>To be completed by Physician</i>		
Clinical Finding					
Date	CPT Code	Treatment	Qty	Unit Price	
05-Oct-2024	96375	Therapeutic, prophylactic, or diagnostic injection (Co.Pay)	1	10.80	
05-Oct-2024	9	Consultation GP (General Consultation)	1	30.00	
05-Oct-2024	86677	Antibody; Helicobacter pylori (Lab)	1	28.80	
05-Oct-2024	0005-136504-1021	SCOPINAL (Pharmacy)	1	4.60	
05-Oct-2024	96372	Therapeutic, prophylactic, or diagnostic injection (Co.Pay)	1	9.00	
05-Oct-2024	96365	Intravenous infusion, for therapy, prophylaxis, or (Co.Pay)	1	46.80	
05-Oct-2024	0005-242802-0781	PANTONIX 40MG I.V.-(PANTOPRAZOLE (AS SODIUM) : 40 (Pharmacy)	1	29.50	
05-Oct-2024	0195-107704-0801	CEFTRIAXONE-TABUK IV (Pharmacy)	1	48.50	
05-Oct-2024	81001	Urinalysis, by dip stick or tablet reagent for bil (Lab)	1	6.30	
				242.20	

Date	CPT Code	Treatment	Qty	Unit Price
05-Oct-2024	86140	C-reactive protein; (Lab)	1	12.60
05-Oct-2024	85025	Blood count; complete (CBC), automated (Hgb, Hct, (Lab)	1	15.30
				242.20

Cause	☐ Physical Illness	☐ Accident	☐ Maternity	☐ Preventive	☐ Psychiatric	☐ Dental	☐ Work Related
☐ Other(s) Explain							

Assessment/ Diagnosis	☐ Acute	☐ Chronic	☐ Confirmed	☐ Suspected
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Type	Date	Doctor	ICD Code	Diagnosis	Notes	year	Problem Role
Primary	05-Oct-2024	Humaira	K29.00	Acute gastritis without bleeding			Admitting Provider
Secondary	05-Oct-2024	Humaira	N39.0	Urinary tract infection, site not specified			Admitting Provider
Secondary	05-Oct-2024	Humaira	R50.9	Fever, unspecified			Admitting Provider
Secondary	05-Oct-2024	Humaira	R05	Cough			Admitting Provider
Secondary	05-Oct-2024	Humaira	J06.9	Acute upper respiratory infection, 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

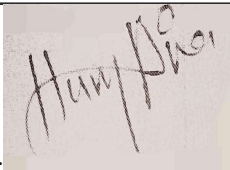
Discharge summary, Itemized Invoices, Report, Results should be attached

Length of stay:	Provider: AL MADALLAH RN4	Cost:
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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	
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Tel/Fax: 0524244416

Signature & Stamp:		
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Date: 05-10-2024	Date: 05-10-2024
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Claims should be submitted with supporting documents within 30 days from date of service or as per contract.