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:	06-Oct-2024	**Healthcare Provider:**	CITICARE MEDICAL CENTER LLC			
PATIENT INFORMATION						
Patient's Name (as on card)	MOHAMED HAMDY MOHAMED KHODEIR	○ Mr. ○ Mrs. ○ Ms.				
Card #	Policy No.	Birth Date :	06-May-1986 *dd mm yy*	**Sex:**	Male	
784-1986-5828590-7						
INFORMATION		***To be completed by Physician***				
Date of present symptoms:	06/10/2024 *dd mm yy*	Symptom(s) as described by Patient:				

Complaint

cofever on and off running nose pain in throat bodyapain 29th sep. 2024

oe redness around the mouth

chest is clear no added sound

restless

smoker

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
06-Oct-2024	9	Consultation GP **(General Consultation)**	1	**30.00**
06-Oct-2024	96372	Therapeutic, prophylactic, or diagnostic injection **(Co.Pay)**	1	**9.00**
06-Oct-2024	96365	Intravenous infusion, for therapy, prophylaxis, or **(Co.Pay)**	1	**46.80**
06-Oct-2024	94640	Pressurized or nonpressurized inhalation treatment **(Co.Pay)**	1	**14.40**
06-Oct-2024	0188-135906-2441	PULMICORT-(BUDESONIDE : 0.5 MG/ML) SUSPENSION FOR **(Pharmacy)**	1	**10.48**
06-Oct-2024	0005-149902-1021	CLOFEN **(Pharmacy)**	1	**6.50**
06-Oct-2024	0195-107704-0801	CEFTRIAXONE-TABUK IV **(Pharmacy)**	1	**48.50**
06-Oct-2024	86140	C-reactive protein; **(Lab)**	1	**12.60**
06-Oct-2024	85025	Blood count; complete (CBC), automated (Hgb, Hct, **(Lab)**	1	**15.30**
				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	06-Oct-2024	Humaira	J02.9	Acute pharyngitis, unspecified			Admitting Provider
Secondary	06-Oct-2024	Humaira	R50.9	Fever, unspecified			Admitting Provider
Secondary	06-Oct-2024	Humaira	R52	Pain, unspecified			Admitting Provider
Secondary	06-Oct-2024	Humaira	K29.00	Acute gastritis without bleeding			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

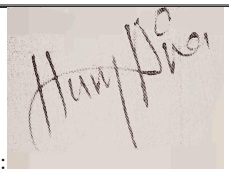
Length of stay:	**Provider: AL MADALLAH RN4**	**Cost:**

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:



Date: 06-10-2024

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