AL MADALLAH Form

almadallah Healthcare Management

Claim Form

استمـــارة 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:	08-Oct-2024	**Healthcare Provider:**	CITICARE MEDICAL CENTER LLC

PATIENT INFORMATION

Patient's Name (as on card)	MUHAMMAD ADNAN FAZAL REHMAN	○ Mr. ○ Mrs. ○ Ms.			
Card #	Policy No.	Birth Date :	01-Jan-1988	**Sex:**	Male
784-1987-0462425-7	IM237EA NLSB		*dd mm yy*		

INFORMATION

To be completed by Physician

Date of present symptoms:	08/10/2024 *dd mm yy*	Symptom(s) as described by Patient:

Complaint

PC: Generalised bone pains, weakness and tiredness

Vitamin D deficiency suspected.

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
08-Oct-2024	9	Consultation GP (General Consultation)	1	**30.00**
				30.00

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	08-Oct-2024	Enomen Goodluck	E55.9	Vitamin D deficiency, unspecified			Admitting Provider
Secondary	08-Oct-2024	Enomen Goodluck	R53.1	Weakness			Admitting Provider
Secondary	08-Oct-2024	Enomen Goodluck	M79.10	Myalgia, unspecified site			Admitting Provider
Secondary	08-Oct-2024	Enomen Goodluck	G72.9	Myopathy, 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:

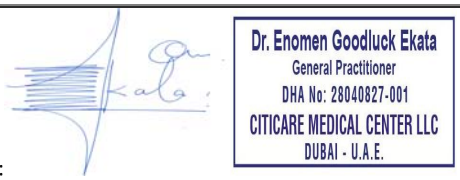
IN-PATIENT

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: Enomen Goodluck		**Patient/Guardian signature**	

Tel/Fax: 1234567	
Signature & Stamp: 	
Date: 08-10-2024	Date: 08-10-2024

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