



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:	11-Oct-2024	Healthcare Provider:	CITICARE MEDICAL CENTER LLC
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PATIENT INFORMATION

Patient's Name (as on card)	NICA MAE BRIZ	☐ Mr. ☐ Mrs. ☐ Ms.		
Card #	Policy No.	Birth Date :	07-Aug-1995	Sex: Female
784-1995-5073985-0			dd mm yy	

INFORMATION

To be completed by Physician

Date of present symptoms:	11/10/2024	Symptom(s) as described by Patient:
	dd mm yy	

Complaint

PC: COUGH

ASTHMAIC KNOWN

HYPERLIPIDEMIA

LOW BACK PAIN

HYPERTENSIVE KNOWN

Pre-existing Condition(s) being treated for : Chronic Medications: Family History of any Illness	☐ No	☐ Yes	If Yes Specify
	☐ No	☐ Yes	
	☐ No	☐ Yes	

OBJECTIVE/ASSESSMENT

To be completed by Physician

Clinical Finding

Date	CPT Code	Treatment	Qty	Unit Price
11-Oct-2024	80061	Lipid panel This panel must include the following: (Lab)	1	58.50
11-Oct-2024	86140	C-reactive protein; (Lab)	1	17.10
11-Oct-2024	85025	Blood count; complete (CBC), automated (Hgb, Hct, (Lab)	1	18.00
11-Oct-2024	9	Consultation GP (General Consultation)	1	35.00
				128.60

Cause	☐ Physical Illness	☐ Accident	☐ Maternity	☐ Preventive	☐ Psychiatric	☐ Dental	☐ Work Related
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☐ Other(s) Explain	
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Assessment/ Diagnosis	☐ Acute	☐ Chronic	☐ Confirmed	☐ Suspected
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Type	Date	Doctor	ICD Code	Diagnosis	Notes	year	Problem Role
Primary	11-Oct-2024	AHSAN HUSSAIN	J20.9	Acute bronchitis, unspecified			Admitting Provider
Secondary	11-Oct-2024	AHSAN HUSSAIN	M54.5	Low back pain			Admitting Provider
Secondary	11-Oct-2024	AHSAN HUSSAIN	E78.5	Hyperlipidemia, unspecified			Admitting Provider
Secondary	11-Oct-2024	AHSAN HUSSAIN	I10	Essential (primary) hypertension			Admitting Provider
Secondary	11-Oct-2024	AHSAN HUSSAIN	J45.20	Mild intermittent asthma, uncomplicated			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:		

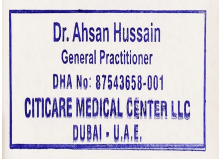
IN-PATIENT**Discharge summary, Itemized Invoices, Report, Results should be attached**

Length of stay:	Provider: AL MADALLAH RN3	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: AHSAN HUSSAIN	Patient/Guardian signature
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Tel/Fax: 0521644729

 	
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Signature & Stamp:

Date: 11-10-2024	Date: 11-10-2024
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Claims should be submitted with supporting documents within 30 days from date of service or as per contract.