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:	11-Oct-2024	**Healthcare Provider:**	CITICARE MEDICAL CENTER LLC

PATIENT INFORMATION

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

INFORMATION

To be completed by Physician

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

Complaint

PC: COUGH

ASTHMAIC KNOWN

HYPERLIPIDEMIA

LOW BACK PAIN

HYPERTENSIVE KNOWN

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
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**
☐ **Other(s)** Explain							

Assessment/ Diagnosis	☐ **Acute**	☐ **Chronic**	☐ **Confirmed**	☐ **Suspected**

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:**

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**	
Tel/Fax: 0521644729			
Signature & Stamp: 			
Date: 11-10-2024	Date: 11-10-2024		
Claims should be submitted with supporting documents within 30 days from date of service or as per contract.			