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)	Omar Rafat Mohamed Khamis Silaman	○ Mr. ○ Mrs. ○ Ms.				
Card #	Policy No.	Birth Date :	17-Jul-1997 *dd mm yy*	**Sex:**	Male	
784-1997-9522957-6						
INFORMATION		***To be completed by Physician***				
Date of present symptoms:	11/10/2024 *dd mm yy*	Symptom(s) as described by Patient:				

Complaint

co pain inthe lower abdominal region fever on and off dark colour of urine pain in the urine 2nd oct 2024

oe 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	***To be completed by Physician***			

Clinical Finding

Date	CPT Code	Treatment	Qty	Unit Price
11-Oct-2024	9	Consultation GP **(General Consultation)**	1	**30.00**
11-Oct-2024	81001	Urinalysis, by dip stick or tablet reagent for bil **(Lab)**	1	**6.30**
11-Oct-2024	86140	C-reactive protein; **(Lab)**	1	**12.60**
11-Oct-2024	85025	Blood count; complete (CBC), automated (Hgb, Hct, **(Lab)**	1	**15.30**
				64.20

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	Humaira	N39.0	Urinary tract infection, site not specified			Admitting Provider
Secondary	11-Oct-2024	Humaira	R50.9	Fever, unspecified			Admitting Provider
Secondary	11-Oct-2024	Humaira	R30.9	Painful micturition, 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

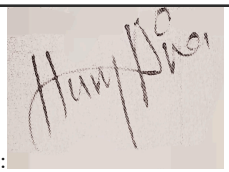
Length of stay:	**Provider: AL MADALLAH RN4**	**Cost:**

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: Humaira		**Patient/Guardian signature**	

Tel/Fax: 0524244416

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.