

AL MADALLAH Form



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)	Shoeb Yakub Shaikh	☐ Mr. ☐ Mrs. ☐ Ms.
Card #	Policy No.	Birth Date : 20-Nov-1988
784-1988-1316816-2		dd mm yy Sex:

INFORMATION

To be completed by Physician

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

Complaint

co fever on and off taking penadol at home running nose bodyache 7th oct 2024

oe

chest is clear no added sounds

restless

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

OBJECTIVE/ASSESSMENT

To be completed by Physician

Clinical Finding

Date	CPT Code	Treatment
11-Oct-2024	94640	Pressurized or nonpressurized inhalation treatment (Co.Pay)
11-Oct-2024	0188-135906-2441	PULMICORT (Pharmacy)
11-Oct-2024	96372	Therapeutic, prophylactic, or diagnostic injection (Co.Pay)
11-Oct-2024	96365	Intravenous infusion, for therapy, prophylaxis, or (Co.Pay)
11-Oct-2024	0005-149902-1021	CLOFEN -(DICLOFENAC SODIUM : 75 MG/3ML) SOLUTION (Pharmacy)

Date	CPT Code	Treatment
11-Oct-2024	0195-107704-0801	CEFTRIAXONE-TABUK IV (Pharmacy)
11-Oct-2024	86140	C-reactive protein; (Lab)
11-Oct-2024	85025	Blood count; complete (CBC), automated (Hgb, Hct, (Lab)
11-Oct-2024	9	Consultation GP (General Consultation)

Cause	☐ Physical Illness	☐ Accident	☐ Maternity	☐ Preventive	☐ Psychiatric	☐ Dental
☐ Other(s) Explain						

Assessment/ Diagnosis	☐ Acute	☐ Chronic	☐ Confirmed
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Type	Date	Doctor	ICD Code	Diagnosis	Notes	
Primary	11-Oct-2024	Humaira	J06.9	Acute upper respiratory infection, unspecified		
Secondary	11-Oct-2024	Humaira	R50.9	Fever, unspecified		
Secondary	11-Oct-2024	Humaira	J30.9	Allergic rhinitis, unspecified		
Secondary	11-Oct-2024	Humaira	K29.00	Acute gastritis without bleeding		

MEDICAL PLAN

Itemized Original Invoices & Applicable Prescriptions/Reports/Results must be enclosed to consider

☐ Consultation	☐ Physiotherapy	☐ Laboratory	☐ Radiology/Other
		For Almadallah's Use	
Pre-authorization Required for:		As per agreed tariff	
Full details of proposed treatment/Surgery/Medicine:		Approval Code:	

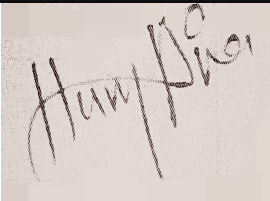
IN-PATIENT

Discharge summary, Itemized Invoices, Report, Results should be attached

Length of stay:	Provider: AL MADALLAH RN4	Cost:
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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 party to provide any information regarding my medical conditions & history to **ALMADALLAH** for the purpose of determining insurance benefits

Treating Physician Name: Humaira	Patient/Guardian signature
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Tel/Fax: 0524244416		
Signature & Stamp:  Dr. Humaira Mumtaz General Practitioner DHA No: 54155530-002 CITICARE MEDICAL CENTER LLC DUBAI - U.A.E.		
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.
