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:	15-Oct-2024	**Healthcare Provider:**	CITICARE MEDICAL CENTER LLC				
PATIENT INFORMATION							
Patient's Name (as on card)	Nielle Anne Alivio Saplot	○ Mr. ○ Mrs. ○ Ms.					
Card #	Policy No.	Birth Date :	20-Sep-1991 *dd mm yy*	**Sex:**	Female		
784-1997-9363031-2							
INFORMATION		***To be completed by Physician***					
Date of present symptoms:	15/10/2024 *dd mm yy*	Symptom(s) as described by Patient:					

Complaint

PC: ASTHMATIC KNOWN

PSORIASIS

FUNGAL INFECTION FEET

LOW BACK PAIN

STOMACH PAIN

HERPESVIRAL INFECTION

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
15-Oct-2024	9	Consultation Gp (General Consultation)	1	60.00
				60.00

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	15-Oct-2024	AHSAN HUSSAIN	J45.20	Mild intermittent asthma, uncomplicated			Admitting Provider
Secondary	15-Oct-2024	AHSAN HUSSAIN	L40.9	Psoriasis, unspecified			Admitting Provider
Secondary	15-Oct-2024	AHSAN HUSSAIN	B35.3	Tinea pedis			Admitting Provider
Secondary	15-Oct-2024	AHSAN HUSSAIN	M54.5	Low back pain			Admitting Provider

Type	Date	Doctor	ICD Code	Diagnosis	Notes	year	Problem Role
Secondary	15-Oct-2024	AHSAN HUSSAIN	K21.9	Gastro-esophageal reflux disease without esophagitis			Admitting Provider
Secondary	15-Oct-2024	AHSAN HUSSAIN	B00.9	Herpesviral infection, 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: ALMadallah GN+ GN RN GOVT POLICE DEWA**	**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:

Dr. Ahsan Hussain
General Practitioner
DHA No: 87543658-001
CITICARE MEDICAL CENTER LLC
DUBAI - U.A.E.

Date: 15-10-2024	Date: 15-10-2024

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