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)	GILMARK ISIDRO BAUTISTA	○ Mr. ○ Mrs. ○ Ms.				
Card #	Policy No.	Birth Date :	05-Dec-1984 dd mm yy	Sex:	Male	
784-1984-9714952-0						
INFORMATION		*To be completed by Physician*				
Date of present symptoms:	15/10/2024 dd mm yy	Symptom(s) as described by Patient:				

Complaint

PC : COUGH

FEVER

COLD

ASTHMATIC KNOWN

ANAL FISSURE

CONSTIPATION

PAIN IN THIGH RIGHT

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	J20.9	Acute bronchitis, unspecified			Admitting Provider
Secondary	15-Oct-2024	AHSAN HUSSAIN	J00	Acute nasopharyngitis [common cold]			Admitting Provider
Secondary	15-Oct-2024	AHSAN HUSSAIN	J06.9	Acute upper respiratory infection, unspecified			Admitting Provider
Secondary	15-Oct-2024	AHSAN HUSSAIN	J45.20	Mild intermittent asthma, uncomplicated			Admitting Provider
Secondary	15-Oct-2024	AHSAN HUSSAIN	G43.D0	Abdominal migraine, not intractable			Admitting Provider
Secondary	15-Oct-2024	AHSAN HUSSAIN	K60.2	Anal fissure, unspecified			Admitting Provider
Secondary	15-Oct-2024	AHSAN HUSSAIN	M79.651	Pain in right thigh			Admitting Provider
Secondary	15-Oct-2024	AHSAN HUSSAIN	K59.00	Constipation, 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

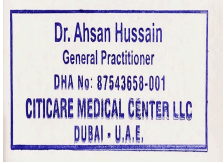
		For Almadallah's Use only
Pre-authorization Required for:		As per agreed tariff
Full details of proposed treatment/Surgery/Medicine:		Approval Code:

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:  			
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.			