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:	18-Oct-2024	Healthcare Provider:	CITICARE MEDICAL CENTER LLC

PATIENT INFORMATION

Patient's Name (as on card)	Cyrstel Rondolo Ludovice	○ Mr. ○ Mrs. ○ Ms.			
Card #	Policy No.	Birth Date :	26-Feb-1987 (dd mm yy)	Sex:	Female
784-1987-3619825-4					

INFORMATION

To be completed by Physician

Date of present symptoms:	18/10/2024 (dd mm yy)	Symptom(s) as described by Patient:

Complaint

PC: ASTHMATIC KNOWN

PSORIASIS

HYPERGLYCEMIA

LOW BACK PAIN

HYPERTENSIVE KNOWN

STOMACH PAIN

CAME TO REFIL MEDICATION

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
18-Oct-2024	82947	Glucose; quantitative, blood (except reagent strip **(Lab)**	1	**6.30**
18-Oct-2024	9	Consultation GP **(General Consultation)**	1	**30.00**
18-Oct-2024	80061	Lipid panel This panel must include the following: **(Lab)**	1	**44.10**
18-Oct-2024	83036	Hemoglobin; glycosylated (A1C) **(Lab)**	1	**16.20**
				96.60

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	18-Oct-2024	AHSAN HUSSAIN	J45.20	Mild intermittent asthma, uncomplicated			Admitting Provider
Secondary	18-Oct-2024	AHSAN HUSSAIN	L40.9	Psoriasis, unspecified			Admitting Provider
Secondary	18-Oct-2024	AHSAN HUSSAIN	R73.9	Hyperglycemia, unspecified			Admitting Provider
Secondary	18-Oct-2024	AHSAN HUSSAIN	M54.5	Low back pain			Admitting Provider
Secondary	18-Oct-2024	AHSAN HUSSAIN	I10	Essential (primary) hypertension			Admitting Provider
Secondary	18-Oct-2024	AHSAN HUSSAIN	K21.9	Gastro-esophageal reflux disease without esophagitis			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: AHSAN HUSSAIN		**Patient/Guardian signature**	
Tel/Fax: 0521644729			
Signature & Stamp: 			
Date: 18-10-2024		Date: 18-10-2024	

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