

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:	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	Sex:	Female
784-1987-3619825-4			dd mm yy		
INFORMATION					
<i>To be completed by Physician</i>					
Date of present symptoms:	18/10/2024	Symptom(s) as described by Patient:			
	dd mm yy				
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		
Chronic Medications:		☐ No	☐ Yes	If Yes Specify	
Family History of any Illness		☐ No	☐ Yes		
OBJECTIVE/ASSESSMENT					
<i>To be completed by Physician</i>					
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

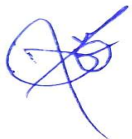
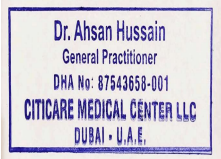
Discharge summary, Itemized Invoices, Report, Results should be attached

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	
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Tel/Fax: 0521644729

 	
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Signature & Stamp:

Date: 18-10-2024

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