

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)	RITCHELLE JAY CUEVAS		☐ Mr. ☐ Mrs. ☐ Ms.				
Card #	Policy No.	Birth Date :	16-Aug-1983	Sex:	Male		
784-1983-9536362-9			dd mm yy				
INFORMATION			To be completed by Physician				
Date of present symptoms:	18/10/2024	Symptom(s) as described by Patient:					
	dd mm yy						
Complaint							
PC:COUGH ASTHMATIC KNOWN FUNGAL INJFECTION LOW BACK PAIN MIGRAAINE CAME TO REFILL 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			To be completed by Physician				
Clinical Finding							
Date	CPT Code	Treatment	Qty	Unit Price			
18-Oct-2024	9	Consultation Gp (General Consultation)	1	60.00			
18-Oct-2024	86140	C-reactive protein; (Lab)	1	12.60			
18-Oct-2024	85025	Blood count; complete (CBC), automated (Hgb, Hct, (Lab)	1	15.30			
				87.90			
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	J20.9	Acute bronchitis, unspecified			Admitting Provider
Secondary	18-Oct-2024	AHSAN HUSSAIN	J45.20	Mild intermittent asthma, uncomplicated			Admitting Provider

Type	Date	Doctor	ICD Code	Diagnosis	Notes	year	Problem Role
Secondary	18-Oct-2024	AHSAN HUSSAIN	B35.3	Tinea pedis			Admitting Provider
Secondary	18-Oct-2024	AHSAN HUSSAIN	M54.5	Low back pain			Admitting Provider
Secondary	18-Oct-2024	AHSAN HUSSAIN	G43.009	Migraine w/o aura, not intractable, w/o status migrainosus			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

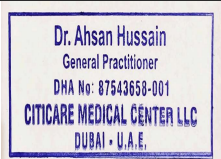
Discharge summary, Itemized Invoices, Report, Results should be attached

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.