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:	23-Oct-2024	**Healthcare Provider:**	CITICARE MEDICAL CENTER LLC

PATIENT INFORMATION

Patient's Name (as on card)	AMIR JAWED ABBASI JAWED MUMTAZ ABBASI	○ Mr. ○ Mrs. ○ Ms.			
Card #	Policy No.	Birth Date :	04-Feb-1988 *dd mm yy*	**Sex:**	Unknown
784-1988-5909528-7					

INFORMATION

To be completed by Physician

Date of present symptoms:	23/10/2024 *dd mm yy*	Symptom(s) as described by Patient:

Complaint

co fever on and off running nose dry cough ear pain left side 19th oct 2024

oe

chest is congested no added sounds

restless in ear red bulging of the skin is there

smoker

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
23-Oct-2024	9	Consultation GP **(General Consultation)**	1	**30.00**
23-Oct-2024	0195-107704-0802	CEFTRIAXONE SODIUM-Ceftriaxone-Tabuk **(Pharmacy)**	1	**48.50**
23-Oct-2024	96365	Intravenous infusion, for therapy, prophylaxis, or **(Co.Pay)**	1	**46.80**
23-Oct-2024	0005-149902-1021	CLOFEN **(Pharmacy)**	1	**6.50**
23-Oct-2024	96372	Therapeutic, prophylactic, or diagnostic injection **(Co.Pay)**	1	**9.00**
23-Oct-2024	9	Consultation GP **(General Consultation)**	1	**30.00**
23-Oct-2024	0005-149902-1021	CLOFEN **(Pharmacy)**	1	**6.50**
23-Oct-2024	0195-107704-0801	CEFTRIAXONE-TABUK IV **(Pharmacy)**	1	**48.50**
23-Oct-2024	85025	Blood count; complete (CBC), automated (Hgb, Hct, **(Lab)**	1	**0.00**
				225.80

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	23-Oct-2024	Humaira	H66.92	Otitis media, unspecified, left ear			Admitting Provider
Secondary	23-Oct-2024	Humaira	J06.9	Acute upper respiratory infection, unspecified			Admitting Provider
Secondary	23-Oct-2024	Humaira	R05	Cough			Admitting Provider
Secondary	23-Oct-2024	Humaira	J30.9	Allergic rhinitis, unspecified			Admitting Provider
Secondary	23-Oct-2024	Humaira	R50.9	Fever, 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

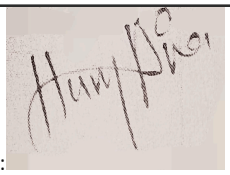
Length of stay:	**Provider: AL MADALLAH RN4**	**Cost:**

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: Humaira		**Patient/Guardian signature**	

Tel/Fax: 0524244416

Signature & Stamp:



Dr. Humaira Mumtaz
General Practitioner
DHA No: 54155530-002
CITICARE MEDICAL CENTER LLC
DUBAI - U.A.E.

Date: 23-10-2024	Date: 23-10-2024

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