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

PATIENT INFORMATION

Patient's Name (as on card)	Abdul Rasheed Attathodi Abdu Rahiman	○ Mr. ○ Mrs. ○ Ms.		
Card #	Policy No.	Birth Date :	28-Feb-1990	Sex:
784-1990-9194632-9			dd mm yy	

INFORMATION

To be completed by Physician

Date of present symptoms:	28/10/2024 (dd mm yy)	Symptom(s) as described by Patient:

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
28-Oct-2024	0195-107704-0801	CEFTRIAXONE-TABUK IV **(Pharmacy)**
28-Oct-2024	96365	Intravenous infusion, for therapy, prophylaxis, or **(Co.Pay)**
28-Oct-2024	9.01	Follow Up - Consultation GP **(General Consultation)**

Cause	☐ Physical Illness	☐ Accident	☐ Maternity	☐ Preventive	☐ Psychiatric	☐ Denta
☐ Other(s) Explain						

Assessment/ Diagnosis	☐ Acute	☐ Chronic	☐ Confirme

Type	Date	Doctor	ICD Code	Diagnosis	Notes
Primary	28-Oct-2024	Humaira	J06.9	Acute upper respiratory infection, unspecified	
Secondary	28-Oct-2024	Humaira	R05	Cough	
Secondary	28-Oct-2024	Humaira	R50.9	Fever, unspecified	
Secondary	28-Oct-2024	Humaira	J30.9	Allergic rhinitis, unspecified	
Secondary	28-Oct-2024	Humaira	K29.00	Acute gastritis without bleeding	

MEDICAL PLAN

Itemized Original Invoices & Applicable Prescriptions/Reports/Results must be enclosed to consid

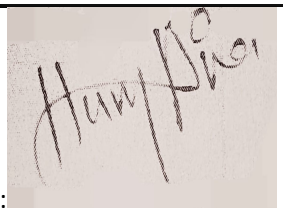
☐ Consultation	☐ Physiotherapy	☐ Laboratory	☐ Radiology/Other
			For Almadallah's U
Pre-authorization Required for:			As per agreed tariff
Full details of proposed treatment/Surgery/Medicine:			Approval Code:

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 ot 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: 		
Date: 28-10-2024		Date: 28-10-2024

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