AL MADALLAH Form

almadallah Healthcare Management

# Claim Form

استمـــارة 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: | 29-Oct-2024 | Healthcare Provider: | CITICARE MEDICAL CENTER LLC | | | |
|---|---|---|---|---|---|---|
| **PATIENT INFORMATION** | | | | | | |
| Patient's Name (as on card) | Khulood Mahmood | ○ Mr. ○ Mrs. ○ Ms. | | | | |
| Card # | Policy No. | Birth Date : | 22-Aug-1990 dd mm yy | Sex: | Female | |
| 784-1990-5937491-0 | | | | | | |
| **INFORMATION** | | To be completed by Physician | | | | |
| Date of present symptoms: | 29/10/2024 dd mm yy | Symptom(s) as described by Patient: | | | | |

**Complaint**

PC: Severe pain on the left ankle since the past 3days.

Swelling on the affected joint.

Had recently joined the police force and is currently in training.

| | | | | |
|---|---|---|---|---|
| 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 |
|---|---|---|---|---|
| 29-Oct-2024 | 0005-149902-1021 | CLOFEN (Pharmacy) | 1 | 6.50 |
| 29-Oct-2024 | 96372 | Therapeutic, Prophylactic, Or Diagnostic Injection (Co.Pay) | 1 | 19.00 |
| 29-Oct-2024 | 9 | Consultation Gp (General Consultation) | 1 | 60.00 |
| | | | | 85.50 |

| 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 | 29-Oct-2024 | Enomen Goodluck | M19.072 | Primary osteoarthritis, left ankle and foot | | | Admitting Provider |
| Secondary | 29-Oct-2024 | Enomen Goodluck | R52 | Pain, unspecified | | | Admitting Provider |
| Secondary | 29-Oct-2024 | Enomen Goodluck | R60.9 | Edema, unspecified | | | Admitting Provider |

**MEDICAL PLAN**

***Itemized Original Invoices & Applicable Prescriptions/Reports/Results must be enclosed to consider the claim***

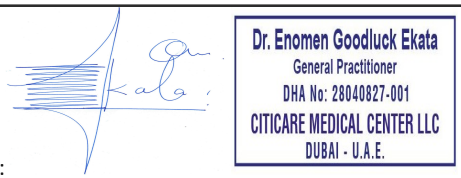
| ☐ **Consultation** | ☐ **Physiotherapy** | ☐ **Laboratory** | ☐ **Radiology/Other** | ☐ **Pharmacy** |
|---|---|---|---|---|
| | | | For Almadallah's Use only | |
| Pre-authorization Required for: | | | As per agreed tariff | |
| Full details of proposed treatment/Surgery/Medicine: | | | Approval Code: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

## IN-PATIENT

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

| **Length of stay:** | **Provider: ALMadallah GN+ GN RN GOVT POLICE DEWA** | **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: Enomen Goodluck** | | **Patient/Guardian signature** | |
|---|---|---|---|
| **Tel/Fax:** 1234567 | | | |
| Signature & Stamp:   | | | |
| Date: 29-10-2024 | Date: 29-10-2024 | | |

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