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:	02-Nov-2024	**Healthcare Provider:**	CITICARE MEDICAL CENTER LLC

PATIENT INFORMATION

Patient's Name (as on card)	DEEPAK DARNAL	○ Mr. ○ Mrs. ○ Ms.			
Card #	Policy No.	Birth Date :	16-Jun-1997 *dd mm yy*	**Sex:**	Male
784-1997-5219020-9					

INFORMATION

To be completed by Physician

Date of present symptoms:	02/11/2024 *dd mm yy*	Symptom(s) as described by Patient:	

Complaint

PC: FEVER

COUGH

FLU

SORETHROAT

LOW BACK PAIN

HEADACHE

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
02-Nov-2024	96365	Intravenous infusion, for therapy, prophylaxis, or **(Co.Pay)**	1	**46.80**
02-Nov-2024	9	Consultation GP **(General Consultation)**	1	**30.00**
02-Nov-2024	96372	Therapeutic, prophylactic, or diagnostic injection **(Co.Pay)**	1	**9.00**
02-Nov-2024	96367	Intravenous infusion, for therapy, prophylaxis, or **(Co.Pay)**	2	**22.50**
02-Nov-2024	86140	C-reactive protein; **(Lab)**	1	**12.60**
02-Nov-2024	85025	Blood count; complete (CBC), automated (Hgb, Hct, **(Lab)**	1	**15.30**
02-Nov-2024	94640	Pressurized or nonpressurized inhalation treatment **(Co.Pay)**	1	**14.40**
02-Nov-2024	0188-135906-2441	PULMICORT **(Pharmacy)**	1	**10.48**
02-Nov-2024	0005-174202-0781	RISEK 40MG **(Pharmacy)**	1	**34.00**
02-Nov-2024	0125-122107-1022	DEXAMETHASONE SODIUM PHOSPHATE **(Pharmacy)**	1	**2.34**
02-Nov-2024	2190-106618-1001	PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) S **(Pharmacy)**	1	**8.40**
02-Nov-2024	0195-107704-0801	CEFTRIAXONE SODIUM-Ceftriaxone-Tabuk **(Pharmacy)**	1	**48.50**
				254.32

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	02-Nov-2024	AHSAN HUSSAIN	J06.9	Acute upper respiratory infection, unspecified			Admitting Provider
Secondary	02-Nov-2024	AHSAN HUSSAIN	J00	Acute nasopharyngitis [common cold]			Admitting Provider
Secondary	02-Nov-2024	AHSAN HUSSAIN	M54.5	Low back pain			Admitting Provider
Secondary	02-Nov-2024	AHSAN HUSSAIN	R50.9	Fever, unspecified			Admitting Provider
Secondary	02-Nov-2024	AHSAN HUSSAIN	J20.9	Acute bronchitis, unspecified			Admitting Provider
Secondary	02-Nov-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**	
Tel/Fax: 0521644729			
Signature & Stamp: 			
Date: 02-11-2024		Date: 02-11-2024	

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