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

PATIENT INFORMATION

Patient's Name (as on card)	Kiran Fatima Rauf	○ Mr. ○ Mrs. ○ Ms.			
Card #	Policy No.	Birth Date :	18-May-1989	**Sex:**	Female
784-1989-6573276-5			*dd mm yy*		

INFORMATION

To be completed by Physician

Date of present symptoms:	07/11/2024 *dd mm yy*	Symptom(s) as described by Patient:

Complaint

PC: FLU 1 DAY

COLD

EPIGASTRIC PAIN

GASEOUS ABDOMEN

CONSTIPATION

SNEEZING

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
07-Nov-2024	96367	Intravenous Infusion, For Therapy, Prophylaxis, Or **(Co.Pay)**	3	**30.00**
07-Nov-2024	9	Consultation Gp **(General Consultation)**	1	**60.00**
07-Nov-2024	96372	Therapeutic, Prophylactic, Or Diagnostic Injection **(Co.Pay)**	1	**19.00**
07-Nov-2024	96365	Intravenous Infusion, For Therapy, Prophylaxis, Or **(Co.Pay)**	1	**64.00**
07-Nov-2024	0005-136504-1021	SCOPINAL **(Pharmacy)**	1	**4.60**
07-Nov-2024	0005-174202-0781	RISEK 40MG **(Pharmacy)**	1	**34.00**
07-Nov-2024	0005-150403-1021	PREMOSAN -(METOCLOPRAMIDE : 10 MG/2ML) SOLUTION F **(Pharmacy)**	1	**0.90**
07-Nov-2024	2190-106618-1001	PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) S **(Pharmacy)**	1	**8.40**
				269.40

Date	CPT Code	Treatment	Qty	Unit Price
07-Nov-2024	0195-107704-0801	CEFTRIAXONE-TABUK IV (Pharmacy)	1	48.50
				269.40

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	07-Nov-2024	AHSAN HUSSAIN	J06.9	Acute upper respiratory infection, unspecified			Admitting Provider
Secondary	07-Nov-2024	AHSAN HUSSAIN	J00	Acute nasopharyngitis [common cold]			Admitting Provider
Secondary	07-Nov-2024	AHSAN HUSSAIN	R10.13	Epigastric pain			Admitting Provider
Secondary	07-Nov-2024	AHSAN HUSSAIN	M54.5	Low back pain			Admitting Provider
Secondary	07-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

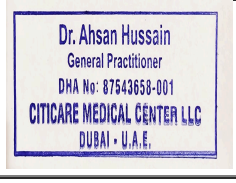
☐ Consultation	☐ Physiotherapy		☐ Laboratory	☐ Radiology/Other	☐ Pharmacy
				For Almadallah's Use only
Pre-authorization Required for:				As per agreed tariff
Full details of proposed treatment/Surgery/Medicine:				Approval Code:

IN-PATIENT

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

Length of stay:	**Provider: 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: AHSAN HUSSAIN		**Patient/Guardian signature**	
Tel/Fax: 0521644729			
Signature & Stamp:  			
Date: 07-11-2024		Date: 07-11-2024	
Claims should be submitted with supporting documents within 30 days from date of service or as per contract.			