

AL MADALLAH Form



Claim Form

استمارة 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:	09-Nov-2024	Healthcare Provider:	CITICARE MEDICAL CENTER LLC
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PATIENT INFORMATION

Patient's Name (as on card)	Shahid Mahmood Muhammad Sharif	☐ Mr. ☐ Mrs. ☐ Ms.			
Card #	Policy No.	Birth Date :	20-Feb-1986	Sex:	Male
784-1986-9454300-4			dd mm yy		

INFORMATION

To be completed by Physician

Date of present symptoms:	09/11/2024	Symptom(s) as described by Patient:
	dd mm yy	

Complaint

PC: SORE THROAT 1 DAY

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
09-Nov-2024	9	Consultation GP (General Consultation)	1	30.00
09-Nov-2024	96372	Therapeutic, prophylactic, or diagnostic injection (Co.Pay)	1	9.00
09-Nov-2024	0125-122107-1022	DEXAMETHASONE SODIUM PHOSPHATE (Pharmacy)	1	2.34
09-Nov-2024	2190-106618-1001	PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) S (Pharmacy)	1	8.40
09-Nov-2024	96365	Intravenous infusion, for therapy, prophylaxis, or (Co.Pay)	1	46.80
09-Nov-2024	0195-107704-0801	CEFTRIAXONE SODIUM-Ceftriaxone-Tabuk (Pharmacy)	1	48.50
				145.04

Cause	☐ Physical Illness	☐ Accident	☐ Maternity	☐ Preventive	☐ Psychiatric	☐ Dental	☐ Work Related
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☐ Other(s) Explain	
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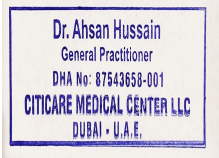
Assessment/ Diagnosis	☐ Acute	☐ Chronic	☐ Confirmed	☐ Suspected
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Type	Date	Doctor	ICD Code	Diagnosis	Notes	year	Problem Role
Primary	09-Nov-2024	AHSAN HUSSAIN	J06.9	Acute upper respiratory infection, unspecified			Admitting Provider
Secondary	09-Nov-2024	AHSAN HUSSAIN	R07.0	Pain in throat			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: 09-11-2024		Date: 09-11-2024
Claims should be submitted with supporting documents within 30 days from date of service or as per contract.		