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:	09-Nov-2024	Healthcare Provider:	CITICARE MEDICAL CENTER LLC

PATIENT INFORMATION

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

INFORMATION

To be completed by Physician

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

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
☐ Other(s) Explain							

Assessment/ Diagnosis	☐ Acute	☐ Chronic	☐ Confirmed	☐ Suspected

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.			