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

PATIENT INFORMATION

Patient's Name (as on card)	MOHAMED HAMDY MOHAMED KHODEIR	○ Mr. ○ Mrs. ○ Ms.			
Card #	Policy No.	Birth Date :	06-May-1986 (dd mm yy)	Sex:	Male
784-1986-5828590-7					

INFORMATION

To be completed by Physician

Date of present symptoms:	10/11/2024 (dd mm yy)	Symptom(s) as described by Patient:

Complaint

PC: Recurrent neck pain, that radiate to both upper limbs,

and associated with tingling (as of electric shock) and numbness down both lower limbs.

Also has similar pain on the low back that radiates down both lower limbs.

There is however no urinary nor fecal incontinence, and no loss of sensation in the perineal region.

Duration of symptoms is one month (8th October, 2024).

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
10-Nov-2024	9	Consultation GP (General Consultation)	1	30.00
				30.00

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	10-Nov-2024	Enomen Goodluck	M47.23	Other spondylosis with radiculopathy, cervicothoracic region			Admitting Provider
Secondary	10-Nov-2024	Enomen Goodluck	M47.25	Other spondylosis with radiculopathy, thoracolumbar region			Admitting Provider
Secondary	10-Nov-2024	Enomen Goodluck	M54.2	Cervicalgia			Admitting Provider

Type	Date	Doctor	ICD Code	Diagnosis	Notes	year	Problem Role
Secondary	10-Nov-2024	Enomen Goodluck	M54.5	Low back pain			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: Enomen Goodluck		**Patient/Guardian signature**	
Tel/Fax: 1234567			
Signature & Stamp: Dr. Enomen Goodluck Ekata, General Practitioner, DHA No: 28040827-001, CITICARE MEDICAL CENTER LLC, DUBAI - U.A.E.			
Date: 10-11-2024		Date: 10-11-2024	

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