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

PATIENT INFORMATION

Patient's Name (as on card)	Nashwa Fouad Artin	○ Mr. ○ Mrs. ○ Ms.		
Card #	Policy No.	Birth Date :	21-Sep-1973	Sex:
784-1973-0247919-7			dd mm yy	

INFORMATION

To be completed by Physician

Date of present symptoms:	13/11/2024 (dd mm yy)	Symptom(s) as described by Patient:

Complaint

co hand stiffness inthe early morning hot feet 6th nov. 2024

chest is clear no added sounds

restless

smoker

she is taking thyroid pills 50 mg daily

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
13-Nov-2024	9	Consultation GP **(General Consultation)**	1
13-Nov-2024	84550	Uric acid; blood **(Lab)**	1
13-Nov-2024	84443	Thyroid stimulating hormone (TSH) **(Lab)**	1

Cause	☐ Physical Illness	☐ Accident	☐ Maternity	☐ Preventive	☐ Psychiatric	☐ Denta

☐ **Other(s)** Explain					
Assessment/ Diagnosis				☐ **Acute**	☐ **Chronic** ☐ **Confirme**

Type	Date	Doctor	ICD Code	Diagnosis	Notes
Primary	13-Nov-2024	Humaira	E79.0	Hyperuricemia w/o signs of inflam arthrit and tophaceous dis	
Secondary	13-Nov-2024	Humaira	E05.90	Thyrotoxicosis, unsp without thyrotoxic crisis or storm	

MEDICAL PLAN

Itemized Original Invoices & Applicable Prescriptions/Reports/Results must be enclosed to consid

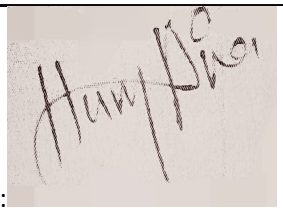
☐ **Consultation**	☐ **Physiotherapy**	☐ **Laboratory**	☐ **Radiology/Other**
			For Almadallah's U
Pre-authorization Required for:			As per agreed tariff
Full details of proposed treatment/Surgery/Medicine:			Approval Code:

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 ot any information regarding my medical conditions & history to **ALMADALLAH** for the purpose of determining insurance benefits

Treating Physician Name: Humaira		**Patient/Guardian signature**
Tel/Fax: 0524244416		
Signature & Stamp:  Dr. Humaira Mumtaz General Practitioner DHA No: 54155530-002 CITICARE MEDICAL CENTER LLC DUBAI - U.A.E.		
Date: 13-11-2024		Date: 13-11-2024

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