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)	SAMER SHAWKY MOTRAN ARMANYOS	○ Mr. ○ Mrs. ○ Ms.		
Card #	Policy No.	Birth Date :	01-Oct-1971	Sex:
784-1971-4037258-8			*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 chest heaviness 9th nov. 2024

diabetic hypertensive

taking already medicine

Current medications include concor 2.5mg dly (morning)

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	Q
13-Nov-2024	84512	Troponin, qualitative **(Lab)**	1
13-Nov-2024	80061	Lipid panel This panel must include the following: **(Lab)**	1
13-Nov-2024	9	Consultation GP **(General Consultation)**	1
13-Nov-2024	93010	Electrocardiogram, routine ECG with at least 12 le **(Co.Pay)**	1

Cause	☐ Physical Illness	☐ Accident	☐ Maternity	☐ Preventive	☐ Psychiatric	☐ Denta
☐ Other(s) Explain						

Assessment/ Diagnosis	☐ Acute	☐ Chronic	☐ Confirme

Type	Date	Doctor	ICD Code	Diagnosis	Notes	year
Primary	13-Nov-2024	Enomen Goodluck	R07.9	Chest pain, unspecified		

MEDICAL PLAN

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

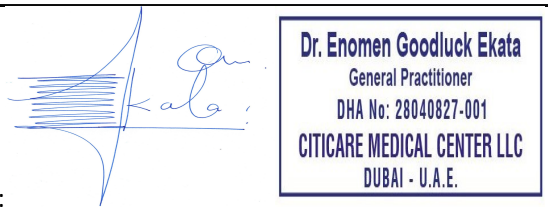
☐ Consultation	☐ Physiotherapy	☐ Laboratory	☐ Radiology/Other
			For Almadallah's U
Pre-authorization Required for:			As per agreed tariff
Full details of proposed treatment/Surgery/Medicine:			Approval Code:

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: Enomen Goodluck		Patient/Guardian signature
Tel/Fax: 1234567		
Signature & Stamp: 		
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.