



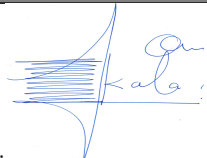
Claim Form

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:	21-Nov-2024	Healthcare Provider:	CITICARE MEDICAL CENTER LLC				
PATIENT INFORMATION							
Patient's Name (as on card)	Ganga Ram Yadav		☐ Mr. ☐ Mrs. ☐ Ms.				
Card #	Policy No.	Birth Date :	10-Mar-1990	Sex:	Male		
784-1990-8058218-4			dd mm yy				
INFORMATION			<i>To be completed by Physician</i>				
Date of present symptoms:	21/11/2024	Symptom(s) as described by Patient:					
	dd mm yy						
Complaint							
PC: nasal congestion, pain in throat, and runny nose. Duration: 3days Not hypertensive and not diabetic. No other medical condition of note.							
Pre-existing Condition(s) being treated for :		☐ No	☐ Yes				
Chronic Medications:		☐ No	☐ Yes	If Yes Specify			
Family History of any Illness		☐ No	☐ Yes				
OBJECTIVE/ASSESSMENT			<i>To be completed by Physician</i>				
Clinical Finding							
Date	CPT Code	Treatment	Qty	Unit Price			
21-Nov-2024	9	Consultation GP (General Consultation)	1	30.00			
21-Nov-2024	86140	C-reactive protein; (Lab)	1	12.60			
21-Nov-2024	85025	Blood count; complete (CBC), automated (Hgb, Hct, (Lab)	1	15.30			
				57.90			
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	21-Nov-2024	Enomen Goodluck	J03.90	Acute tonsillitis, unspecified			Admitting Provider
Secondary	21-Nov-2024	Enomen Goodluck	J01.00	Acute maxillary sinusitis, unspecified			Admitting Provider
Secondary	21-Nov-2024	Enomen Goodluck	J30.9	Allergic rhinitis, unspecified			Admitting Provider
Secondary	21-Nov-2024	Enomen Goodluck	R09.81	Nasal congestion			Admitting Provider
MEDICAL PLAN							
<i>Itemized Original Invoices & Applicable Prescriptions/Reports/Results must be enclosed to consider the claim</i>							
☐ 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:			
Date: 21-11-2024		Date: 21-11-2024	
Claims should be submitted with supporting documents within 30 days from date of service or as per contract.			