



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:	22-Nov-2024	Healthcare Provider:	CITICARE MEDICAL CENTER LLC
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PATIENT INFORMATION

Patient's Name (as on card)	MUHAMMAD ADNAN FAZAL REHMAN	☐ Mr. ☐ Mrs. ☐ Ms.			
Card #	Policy No.	Birth Date :	01-Jan-1988	Sex:	Male
784-1987-0462425-7	IM237EA NLSB		dd mm yy		

INFORMATION

To be completed by Physician

Date of present symptoms:	22/11/2024	Symptom(s) as described by Patient:
	dd mm yy	

Complaint

co muscle pain due to heavy weight lifting 19th nov. 2024

oe chest is clear no added sounds

restless

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

To be completed by Physician

Date	CPT Code	Treatment	Qty	Unit Price
22-Nov-2024	9	Consultation GP (General Consultation)	1	30.00
				30.00

Cause	☐ Physical Illness	☐ Accident	☐ Maternity	☐ Preventive	☐ Psychiatric	☐ Dental	☐ Work Related
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☐ Other(s) Explain	
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Assessment/ Diagnosis	☐ Acute	☐ Chronic	☐ Confirmed	☐ Suspected
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Type	Date	Doctor	ICD Code	Diagnosis	Notes	year	Problem Role
Primary	22-Nov-2024	Humaira	M62.838	Other muscle spasm			Admitting Provider
Secondary	22-Nov-2024	Humaira	R52	Pain, unspecified			Admitting Provider

MEDICAL PLAN

Itemized Original Invoices & Applicable Prescriptions/Reports/Results must be enclosed to consider the claim

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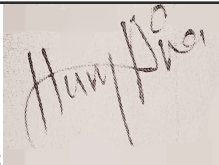
		For Almadallah's Use only
Pre-authorization Required for:		As per agreed tariff
Full details of proposed treatment/Surgery/Medicine:		Approval Code:

IN-PATIENT

Discharge summary, Itemized Invoices, Report, Results should be attached

Length of stay:	Provider: AL MADALLAH RN4	Cost:
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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: Humaira		Patient/Guardian signature		
Tel/Fax: 0524244416				
Signature & Stamp:				
				
Date: 22-11-2024		Date: 22-11-2024		
Claims should be submitted with supporting documents within 30 days from date of service or as per contract.				