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:** | 06-Dec-2024 | **Healthcare Provider:** | CITICARE MEDICAL CENTER LLC |

## PATIENT INFORMATION

| | | | | | |
|---|---|---|---|---|---|
| **Patient's Name (as on card)** | Peris Wangari Kimari | ○ Mr. ○ Mrs. ○ Ms. | | | |
| Card # | Policy No. | Birth Date : | 20-May-1998 *dd mm yy* | **Sex:** | Female |
| 784-1998-7427453-5 | | | | | |

## INFORMATION

*To be completed by Physician*

| | | |
|---|---|---|
| Date of present symptoms: | 06/12/2024 *dd mm yy* | Symptom(s) as described by Patient: |

| | | | | |
|---|---|---|---|---|
| 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 |
|---|---|---|---|---|
| 23-Nov-2024 | 84443 | Thyroid stimulating hormone (TSH) **(Lab)** | 1 | **32.40** |
| 23-Nov-2024 | 85027 | Blood count; complete (CBC), automated (Hgb, Hct, **(Lab)** | 1 | **12.60** |
| 23-Nov-2024 | 76830 | Ultrasound, transvaginal **(Radiology)** | 1 | **140.40** |
| 23-Nov-2024 | 76700 | Ultrasound, abdominal, real time with image docume **(Radiology)** | 1 | **156.60** |
| 23-Nov-2024 | 10 | Consultation Specialist **(General Consultation)** | 1 | **40.00** |
| | | | | **382.00** |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| **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 |
|---|---|---|---|---|---|---|---|
| Secondary | 06-Dec-2024 | MOHAMMED M HAMED | E03.9 | Hypothyroidism, unspecified | | | Admitting Provider |
| Primary | 06-Dec-2024 | MOHAMMED M HAMED | O26.91 | Pregnancy related conditions, unspecified, first trimester | | | 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: MOHAMMED M HAMED** | | **Patient/Guardian signature** |  |
| **Tel/Fax:** 0586108591 | | | |
| Signature & Stamp:   | | | |
| Date: 06-12-2024 | | Date: 06-12-2024 | |
| Claims should be submitted with supporting documents within 30 days from date of service or as per contract. | | | |