

AL MADALLAH Form



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:	25-Nov-2024	Healthcare Provider:	CITICARE MEDICAL CENTER LLC		
PATIENT INFORMATION					
Patient's Name (as on card)	VARUN SAKTHI		☐ Mr. ☐ Mrs. ☐ Ms.		
Card #	Policy No.	Birth Date :		14-Mar-1987	Sex:
784-1987-3074261-0				dd mm yy	
INFORMATION			To be completed by Physician		
Date of present symptoms:	25/11/2024	Symptom(s) as described by Patient:			
	dd mm yy				
Complaint					
PC: hard swelling on the anterior abdominal wall, also has similar mass on the medial aspect of left upper arm and right thigh					
Duration: first noticed over a year ago.					
Exam: Firm swelling, not attached to skin, but fixed on contraction of the anterior abdominal wall muscles.					
patient is reassured					
Pre-existing Condition(s) being treated for :					
Chronic Medications:		☐ No	☐ Yes	If Yes Specify	
Family History of any Illness		☐ No	☐ Yes		
		☐ No	☐ Yes		
OBJECTIVE/ASSESSMENT			To be completed by Physician		
Clinical Finding					
Date	CPT Code	Treatment		Qty	Unit
25-Nov-2024	9	Consultation GP (General Consultation)		1	
Cause	☐ Physical Illness	☐ Accident	☐ Maternity	☐ Preventive	☐ Psychiatric
☐ Other(s) Explain					
Assessment/ Diagnosis			☐ Acute	☐ Chronic	☐ Confirmed

Type	Date	Doctor	ICD Code	Diagnosis	Notes	ye
Primary	25-Nov-2024	Enomen Goodluck	D17.79	Benign lipomatous neoplasm of other sites		

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:	

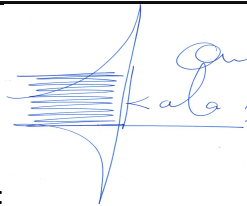
IN-PATIENT**Discharge summary, Itemized Invoices, Report, Results should be attached**

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
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Tel/Fax: 1234567

Signature & Stamp:	
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Dr. Enomen Goodluck Ekata
General Practitioner
DHA No: 28040827-001
CITICARE MEDICAL CENTER LLC
DUBAI - U.A.E.

Date: 25-11-2024	Date: 25-11-2024
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Claims should be submitted with supporting documents within 30 days from date of service or as per contract.