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: | 26-Nov-2024 | Healthcare Provider: | CITICARE MEDICAL CENTER LLC |
|---|---|---|---|

## PATIENT INFORMATION

| Patient's Name (as on card) | Muhammad Hassan Altaf Ahmad | ○ Mr. ○ Mrs. ○ Ms. | | |
|---|---|---|---|---|
| Card # | Policy No. | Birth Date : | 29-Oct-1999 | Sex: |
| 784-1999-6403885-7 | | | *dd mm yy* | |

## INFORMATION

***To be completed by Physician***

| Date of present symptoms: | 26/11/2024 *dd mm yy* | Symptom(s) as described by Patient: |
|---|---|---|

**Complaint**

co fever on and off dry cough pain in throat

23rd nov. 2024

oe chest is congested no added sounds

restless

advise rest for 2 days

| | | | | |
|---|---|---|---|---|
| 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 |
|---|---|---|
| 26-Nov-2024 | 9 | Consultation GP **(General Consultation)** |
| 26-Nov-2024 | 96367 | Intravenous infusion, for therapy, prophylaxis, or **(Co.Pay)** |
| 26-Nov-2024 | 96372 | Therapeutic, prophylactic, or diagnostic injection **(Co.Pay)** |
| 26-Nov-2024 | 96365 | Intravenous infusion, for therapy, prophylaxis, or **(Co.Pay)** |

| Date | CPT Code | Treatment |
|---|---|---|
| 26-Nov-2024 | 94640 | Pressurized or nonpressurized inhalation treatment **(Co.Pay)** |
| 26-Nov-2024 | 0188-135906-2441 | PULMICORT-(BUDESONIDE : 0.5 MG/ML) SUSPENSION FOR **(Pharmacy)** |
| 26-Nov-2024 | 0195-107704-0801 | CEFTRIAXONE-TABUK IV **(Pharmacy)** |
| 26-Nov-2024 | 0005-149902-1021 | CLOFEN -(DICLOFENAC SODIUM : 75 MG/3ML) SOLUTION **(Pharmacy)** |
| 26-Nov-2024 | 2190-106618-1001 | PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) S **(Pharmacy)** |
| 26-Nov-2024 | 86140 | C-reactive protein; **(Lab)** |
| 26-Nov-2024 | 85025 | Blood count; complete (CBC), automated (Hgb, Hct, **(Lab)** |

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

| Assessment/ Diagnosis | ☐ Acute | ☐ Chronic | ☐ Confirme |
|---|---|---|---|

| Type | Date | Doctor | ICD Code | Diagnosis | Notes |
|---|---|---|---|---|---|
| Primary | 26-Nov-2024 | Humaira | J06.9 | Acute upper respiratory infection, unspecified | |
| Secondary | 26-Nov-2024 | Humaira | J30.9 | Allergic rhinitis, unspecified | |
| Secondary | 26-Nov-2024 | Humaira | R05 | Cough | |
| Secondary | 26-Nov-2024 | Humaira | R50.9 | Fever, unspecified | |
| Secondary | 26-Nov-2024 | Humaira | K29.00 | Acute gastritis without bleeding | |

## 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: |
| | | | |
| | | | |

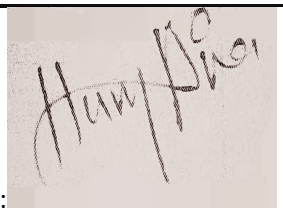
## IN-PATIENT

**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: Humaira | | Patient/Guardian signature |
|---|---|---|

| | |
|---|---|
| **Tel/Fax:** 0524244416 | |
| Signature & Stamp:  Dr. Humaira Mumtaz<br>General Practitioner<br>DHA No: 54155530-002<br>CITICARE MEDICAL CENTER LLC<br>DUBAI - U.A.E. | |
| Date: 26-11-2024 | Date: 26-11-2024 |
| Claims should be submitted with supporting documents within 30 days from date of service or as per contract. | |