

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

Patient's Name (as on card)	ABDUL ARIF BABU BABU	☐ Mr. ☐ Mrs. ☐ Ms.
Card #	Policy No.	Birth Date : 12-Jun-1976
784-1976-2571744-8		dd mm yy Sex:

INFORMATION

To be completed by Physician

Date of present symptoms:	27/11/2024	Symptom(s) as described by Patient:
	dd mm yy	

Complaint

co fever body pain dry cough nasal congestion 23rd nov. 2024

oe chest is congested no added sounds

restless

Pre-existing Condition(s) being treated for :	☐ No	☐ Yes	
Chronic Medications:	☐ No	☐ Yes	If Yes
Family History of any Illness	☐ No	☐ Yes	Specify

OBJECTIVE/ASSESSMENT

To be completed by Physician

Clinical Finding

Date	CPT Code	Treatment
27-Nov-2024	9	Consultation GP (General Consultation)
27-Nov-2024	96367	Intravenous infusion, for therapy, prophylaxis, or (Co.Pay)
27-Nov-2024	94640	Pressurized or nonpressurized inhalation treatment (Co.Pay)
27-Nov-2024	0188-135906-2441	PULMICORT-(BUDESONIDE : 0.5 MG/ML) SUSPENSION FOR (Pharmacy)
27-Nov-2024	96372	Therapeutic, prophylactic, or diagnostic injection (Co.Pay)
27-Nov-2024	96365	Intravenous infusion, for therapy, prophylaxis, or (Co.Pay)

Date	CPT Code	Treatment
27-Nov-2024	0005-149902-1021	CLOFEN (Pharmacy)
27-Nov-2024	2190-106618-1001	PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) S (Pharmacy)
27-Nov-2024	0195-107704-0801	CEFTRIAZONE-TABUK IV (Pharmacy)
27-Nov-2024	86140	C-reactive protein; (Lab)
27-Nov-2024	85025	Blood count; complete (CBC), automated (Hgb, Hct, (Lab)

Cause	☐ Physical Illness	☐ Accident	☐ Maternity	☐ Preventive	☐ Psychiatric	☐ Dental
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☐ Other(s) Explain	
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Assessment/ Diagnosis	☐ Acute	☐ Chronic	☐ Confirmed
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Type	Date	Doctor	ICD Code	Diagnosis	Notes	
Primary	27-Nov-2024	Humaira	J06.9	Acute upper respiratory infection, unspecified		
Secondary	27-Nov-2024	Humaira	R50.9	Fever, unspecified		
Secondary	27-Nov-2024	Humaira	J30.9	Allergic rhinitis, unspecified		
Secondary	27-Nov-2024	Humaira	R05	Cough		
Secondary	27-Nov-2024	Humaira	K29.00	Acute gastritis without bleeding		

MEDICAL PLAN

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

☐ 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

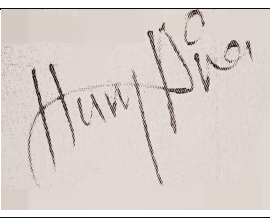
Discharge summary, Itemized Invoices, Report, Results should be attached

Length of stay:	Provider: AL MADALLAH RN4	Cost:
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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 party 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
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Tel/Fax: 0524244416	
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Signature & Stamp:	 	
Date: 27-11-2024	Date: 27-11-2024	
Claims should be submitted with supporting documents within 30 days from date of service or as per contract.		