

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				
PATIENT INFORMATION							
Patient's Name (as on card)	MUHAMMAD ASHIQ KANNANKOT PARA		☐ Mr. ☐ Mrs. ☐ Ms.				
Card #	Policy No.	Birth Date :	26-May-1999	Sex:	Male		
784-1999-2806019-5			dd mm yy				
INFORMATION							
<i>To be completed by Physician</i>							
Date of present symptoms:	27/11/2024	Symptom(s) as described by Patient:					
	dd mm yy						
Complaint							
co fever on and off running nose dry cough 24th 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 Specify			
Family History of any Illness		☐ No	☐ Yes				
OBJECTIVE/ASSESSMENT							
<i>To be completed by Physician</i>							
Clinical Finding							
Date	CPT Code	Treatment	Qty	Unit Price			
27-Nov-2024	9	Consultation GP (General Consultation)	1	30.00			
27-Nov-2024	94640	Pressurized or nonpressurized inhalation treatment (Co.Pay)	1	14.40			
27-Nov-2024	0188-135906-2441	PULMICORT (Pharmacy)	1	10.48			
27-Nov-2024	96372	Therapeutic, prophylactic, or diagnostic injection (Co.Pay)	1	9.00			
27-Nov-2024	96365	Intravenous infusion, for therapy, prophylaxis, or (Co.Pay)	1	46.80			
27-Nov-2024	0005-149902-1021	CLOFEN -(DICLOFENAC SODIUM : 75 MG/3ML) SOLUTION (Pharmacy)	1	6.50			
27-Nov-2024	0195-107704-0801	CEFTRIAXONE-TABUK IV (Pharmacy)	1	48.50			
				165.68			
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
Primary	27-Nov-2024	Humaira	J06.9	Acute upper respiratory infection, unspecified			Admitting Provider

Type	Date	Doctor	ICD Code	Diagnosis	Notes	year	Problem Role
Secondary	27-Nov-2024	Humaira	J30.9	Allergic rhinitis, unspecified			Admitting Provider
Secondary	27-Nov-2024	Humaira	R05	Cough			Admitting Provider
Secondary	27-Nov-2024	Humaira	R50.9	Fever, unspecified			Admitting Provider
Secondary	27-Nov-2024	Humaira	K29.00	Acute gastritis without bleeding			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

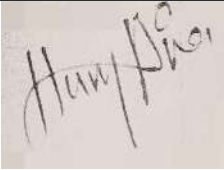
Discharge summary, Itemized Invoices, Report, Results should be attached

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: Humaira	Patient/Guardian signature	
---	-----------------------------------	---

Tel/Fax: 0524244416

 	
---	--

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.