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: 29-Nov-2024	**Healthcare Provider:**	CITICARE MEDICAL CENTER LLC			
PATIENT INFORMATION					
Patient's Name (as on card)	KIAN NILESHKUMAR PANCHAL NILESHKUMAR KIRITKUMAR PANCHAL	○ Mr. ○ Mrs. ○ Ms.			
Card #	Policy No.	Birth Date :	05-Dec-2017 *dd mm yy*	**Sex:**	Male
784-2017-7157079-9					
INFORMATION		***To be completed by Physician***			
Date of present symptoms:	29/11/2024 *dd mm yy*	Symptom(s) as described by Patient:			

Complaint

co fever on and off running nose dry cough 26th nov. 2024

oe chest is congested no added sounds

restless

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
29-Nov-2024	94640	Pressurized or nonpressurized inhalation treatment **(Co.Pay)**	1	**14.40**
29-Nov-2024	0188-135906-2441	PULMICORT-(BUDESONIDE : 0.5 MG/ML) SUSPENSION FOR **(Pharmacy)**	1	**10.48**
29-Nov-2024	9	Consultation GP **(General Consultation)**	1	**30.00**
				54.88

Cause	☐ **Physical Illness**	☐ **Accident**	☐ **Maternity**	☐ **Preventive**	☐ **Psychiatric**	☐ **Dental**	☐ **Work Related**
☐ **Other(s)** Explain							
Assessment/ Diagnosis				☐ **Acute**	☐ **Chronic**	☐ **Confirmed**	☐ **Suspected**

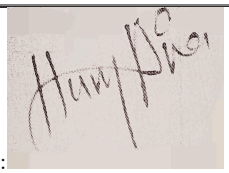
Type	Date	Doctor	ICD Code	Diagnosis	Notes	year	Problem Role
Primary	29-Nov-2024	Humaira	J06.9	Acute upper respiratory infection, unspecified			Admitting Provider
Secondary	29-Nov-2024	Humaira	J30.9	Allergic rhinitis, unspecified			Admitting Provider
Secondary	29-Nov-2024	Humaira	R50.9	Fever, unspecified			Admitting Provider
Secondary	29-Nov-2024	Humaira	R05	Cough			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: 29-11-2024		Date: 29-11-2024	
Claims should be submitted with supporting documents within 30 days from date of service or as per contract.			