



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: 30-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.	
784-2017-7157079-9		Birth Date : 05-Dec-2017 dd mm yy
		Sex: Male

INFORMATION

To be completed by Physician

Date of present symptoms:	30/11/2024 dd mm yy	Symptom(s) as described by Patient:
Pre-existing Condition(s) being treated for : ☐ No ☐ Yes 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
30-Nov-2024	9.01	Follow Up - Consultation GP (General Consultation)	1	0.00
30-Nov-2024	0188-135906-2441	PULMICORT-(BUDESONIDE : 0.5 MG/ML) SUSPENSION FOR (Pharmacy)	1	10.48
30-Nov-2024	94640	Pressurized or nonpressurized inhalation treatment (Co.Pay)	1	14.40
				24.88

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	30-Nov-2024	Humaira	J06.9	Acute upper respiratory infection, unspecified			Admitting Provider
Secondary	30-Nov-2024	Humaira	J30.9	Allergic rhinitis, unspecified			Admitting Provider
Secondary	30-Nov-2024	Humaira	R50.9	Fever, unspecified			Admitting Provider
Secondary	30-Nov-2024	Humaira	R05	Cough			Admitting Provider

MEDICAL PLAN

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

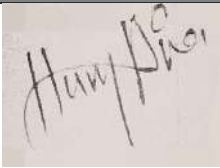
☐ Consultation	☐ Physiotherapy	☐ Laboratory	☐ Radiology/Other	☐ Pharmacy
For Almadallah's Use only				
Pre-authorization Required for:		As per agreed tariff		
Full details of proposed treatment/Surgery/Medicine:		Approval Code:		

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