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:	07-Dec-2024	**Healthcare Provider:**	CITICARE MEDICAL CENTER LLC

PATIENT INFORMATION

Patient's Name (as on card)	Peris Wangari Kimari	○ Mr. ○ Mrs. ○ Ms.			
Card #	Policy No.	Birth Date :	20-May-1998	**Sex:**	Female
784-1998-7427453-5			*dd mm yy*		

INFORMATION

To be completed by Physician

Date of present symptoms:	07/12/2024 *dd mm yy*	Symptom(s) as described by Patient:

Complaint

pc: lethargic for 2 days 04/12/2024

missed period for last 20 days 20/10/2024

dehydration 21/11/2024

diarreha 21/11/2024

nauseous feeling

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
06-Dec-2024	96368	Intravenous infusion, for therapy, prophylaxis, or **(Co.Pay)**	1	**12.60**
06-Dec-2024	0195-107704-0802	CEFTRIAXONE-TABUK IM **(Pharmacy)**	1	**48.50**
06-Dec-2024	2190-106618-1001	PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) S **(Pharmacy)**	1	**8.40**
06-Dec-2024	0131-116601-1001	METRONIDAZOLE-Metronidazole **(Pharmacy)**	1	**9.50**
06-Dec-2024	0102-100104-1001	SODIUM CHLORIDE & DEXTROSE B.P. **(Pharmacy)**	1	**4.50**
06-Dec-2024	0005-150403-1021	PREMOSAN **(Pharmacy)**	1	**0.90**
06-Dec-2024	0125-122107-1022	DEXAMETHASONE SODIUM PHOSPHATE **(Pharmacy)**	1	**2.34**
06-Dec-2024	96365	Intravenous infusion, for therapy, prophylaxis, or **(Co.Pay)**	1	**46.80**
06-Dec-2024	96372	Therapeutic, prophylactic, or diagnostic injection **(Co.Pay)**	2	**9.00**
06-Dec-2024	0005-174202-0781	RISEK 40MG **(Pharmacy)**	1	**34.00**
06-Dec-2024	96361	Intravenous infusion, hydration; each additional h **(Co.Pay)**	1	**10.80**
06-Dec-2024	9	Consultation GP **(General Consultation)**	1	**30.00**
				217.34

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	07-Dec-2024	Humaira	E86.0	Dehydration			Admitting Provider
Secondary	07-Dec-2024	Humaira	R19.7	Diarrhea, unspecified			Admitting Provider
Secondary	07-Dec-2024	Humaira	R11.2	Nausea with vomiting, unspecified			Admitting Provider
Secondary	07-Dec-2024	Humaira	K21.9	Gastro-esophageal reflux disease without esophagitis			Admitting Provider

MEDICAL PLAN

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

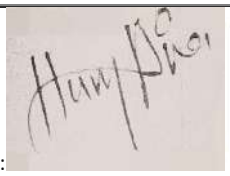
☐ Consultation	☐ Physiotherapy	☐ Laboratory	☐ Radiology/Other	☐ Pharmacy
			For Almadallah's Use only	
Pre-authorization Required for:			As per agreed tariff	
Full details of proposed treatment/Surgery/Medicine:			Approval Code:	

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: 07-12-2024		Date: 07-12-2024	

Claims should be submitted with supporting documents within 30 days from date of service or as per contract.