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

PATIENT INFORMATION

Patient's Name (as on card)	MOHAMED HAMDY MOHAMED KHODEIR	○ Mr. ○ Mrs. ○ Ms.			
Card #	Policy No.	Birth Date :	06-May-1986	**Sex:**	Male
784-1986-5828590-7			*dd mm yy*		

INFORMATION

To be completed by Physician

Date of present symptoms:	08/12/2024 *dd mm yy*	Symptom(s) as described by Patient:

Complaint

co fever on and off diarrhea nausea headache 5th dec. 2024

oe chest is clear no added sounds

restless

smoker

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
08-Dec-2024	96375	Therapeutic, prophylactic, or diagnostic injection **(Co.Pay)**	1	**10.80**
08-Dec-2024	96361	Intravenous infusion, hydration; each additional h **(Co.Pay)**	1	**10.80**
08-Dec-2024	9	Consultation GP **(General Consultation)**	1	**30.00**
08-Dec-2024	0005-150403-1021	PREMOSAN -(METOCLOPRAMIDE : 10 MG/2ML) SOLUTION F **(Pharmacy)**	1	**0.90**
08-Dec-2024	96372	Therapeutic, prophylactic, or diagnostic injection **(Co.Pay)**	1	**9.00**
08-Dec-2024	0005-149902-1021	CLOFEN -(DICLOFENAC SODIUM : 75 MG/3ML) SOLUTION **(Pharmacy)**	1	**6.50**
08-Dec-2024	96365	Intravenous infusion, for therapy, prophylaxis, or **(Co.Pay)**	1	**46.80**
08-Dec-2024	0102-152902-1001	LACTATED RINGERS INJECTION USP **(Pharmacy)**	1	**5.00**
08-Dec-2024	0152-116617-1111	METRONIDAZOLE-Anazol **(Pharmacy)**	1	**8.00**
08-Dec-2024	86140	C-reactive protein; **(Lab)**	1	**12.60**
				155.70

Date	CPT Code	Treatment	Qty	Unit Price
08-Dec-2024	85025	Blood count; complete (CBC), automated (Hgb, Hct, **(Lab)**	1	**15.30**
				155.70

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	08-Dec-2024	Humaira	A09	Infectious gastroenteritis and colitis, unspecified			Admitting Provider
Secondary	08-Dec-2024	Humaira	R19.7	Diarrhea, unspecified			Admitting Provider
Secondary	08-Dec-2024	Humaira	R11.0	Nausea			Admitting Provider
Secondary	08-Dec-2024	Humaira	R50.9	Fever, unspecified			Admitting Provider
Secondary	08-Dec-2024	Humaira	E86.0	Dehydration			Admitting Provider

MEDICAL PLAN

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

☐ Consultation	☐ Physiotherapy	☐ Laboratory	☐ Radiology/Other	☐ Pharmacy

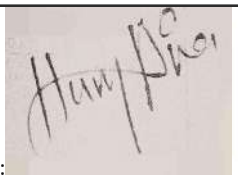
		For Almadallah's Use only
Pre-authorization Required for:		As per agreed tariff
Full details of proposed treatment/Surgery/Medicine:		Approval Code:

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: 08-12-2024		Date: 08-12-2024	

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