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:** | 09-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 *dd mm yy* | **Sex:** | Male | |
| 784-1986-5828590-7 | | | | | | |
| **INFORMATION** | | ***To be completed by Physician*** | | | | |
| Date of present symptoms: | 09/12/2024 *dd mm yy* | Symptom(s) as described by Patient: | | | | |

**Complaint**

Previously seen yestereday

Represented today for similar compaint (lower abdominal pain).

Pain is colicky, waxes and wane and associated with diarrhea for which he has had 6 episodes today.

There is no vomiting and no abdominal distension.

Abdominal Exam:

Marked right iliac fossa tenderness with mild peritonitis (rebound tenderness).

CBC report is not yet available.

Patient is counselled to continue antibiotics as previously prescribed.

| | | | | |
|---|---|---|---|---|
| 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 |
|---|---|---|---|---|
| 09-Dec-2024 | 9.01 | Follow Up - Consultation GP **(General Consultation)** | 1 | **0.00** |
| 09-Dec-2024 | 0102-152902-1001 | LACTATED RINGERS INJECTION USP **(Pharmacy)** | 1 | **5.00** |
| 09-Dec-2024 | 96360 | Intravenous infusion, hydration; initial, 31 minut **(Co.Pay)** | 1 | **32.40** |
| 09-Dec-2024 | 96375 | Therapeutic, prophylactic, or diagnostic injection **(Co.Pay)** | 1 | **10.80** |
| 09-Dec-2024 | 96374 | Therapeutic, prophylactic, or diagnostic injection **(Co.Pay)** | 1 | **10.80** |
| 09-Dec-2024 | 0005-174202-0781 | RISEK 40MG **(Pharmacy)** | 1 | **34.00** |
| 09-Dec-2024 | 0005-136504-1021 | SCOPINAL **(Pharmacy)** | 2 | **4.60** |
| | | | | **97.60** |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| **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 | 09-Dec-2024 | Enomen Goodluck | K36 | Other appendicitis | subacute | | Admitting Provider |
| Secondary | 09-Dec-2024 | Enomen Goodluck | K29.00 | Acute gastritis without bleeding | | | Admitting Provider |
| Secondary | 09-Dec-2024 | Enomen Goodluck | A09 | Infectious gastroenteritis and colitis, unspecified | | | Admitting Provider |
| Secondary | 09-Dec-2024 | Enomen Goodluck | R19.7 | Diarrhea, unspecified | | | Admitting Provider |

## MEDICAL PLAN

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

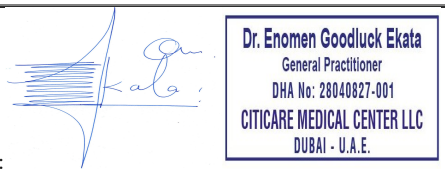
| ☐ **Consultation** | ☐ **Physiotherapy** | ☐ **Laboratory** | ☐ **Radiology/Other** | ☐ **Pharmacy** |
|---|---|---|---|---|
| | | | For Almadallah's Use only | |
| Pre-authorization Required for: | | | As per agreed tariff | |
| Full details of proposed treatment/Surgery/Medicine: | | | Approval Code: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

## 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: Enomen Goodluck** | | **Patient/Guardian signature** |  |
|---|---|---|---|
| **Tel/Fax:** 1234567 | | | |
| Signature & Stamp:   | | | |
| Date: 09-12-2024 | | Date: 09-12-2024 | |
| Claims should be submitted with supporting documents within 30 days from date of service or as per contract. | | | |