



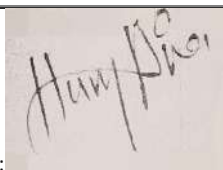
Claim Form

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:	13-Dec-2024	Healthcare Provider:	CITICARE MEDICAL CENTER LLC				
PATIENT INFORMATION							
Patient's Name (as on card)	USMAN SAFDAR SAFDAR MEHMOOD		☐ Mr. ☐ Mrs. ☐ Ms.				
Card #	Policy No.	Birth Date :	19-Jun-1991	Sex:	Male		
784-1991-8719603-7			dd mm yy				
INFORMATION							
To be completed by Physician							
Date of present symptoms:	13/12/2024	Symptom(s) as described by Patient:					
	dd mm yy						
Complaint							
co fever dry cough running nose 10 dec. 2024 oe chest is congested no added sounds restless smoker							
Pre-existing Condition(s) being treated for :		☐ No	☐ Yes				
Chronic Medications:		☐ No	☐ Yes	If Yes Specify			
Family History of any Illness		☐ No	☐ Yes				
OBJECTIVE/ASSESSMENT							
To be completed by Physician							
Clinical Finding							
Date	CPT Code	Treatment	Qty	Unit Price			
13-Dec-2024	96367	Intravenous infusion, for therapy, prophylaxis, or (Co.Pay)	1	22.50			
13-Dec-2024	9	Consultation GP (General Consultation)	1	30.00			
13-Dec-2024	94640	Pressurized or nonpressurized inhalation treatment (Co.Pay)	1	14.40			
13-Dec-2024	0188-135906-2441	PULMICORT-(BUDESONIDE : 0.5 MG/ML) SUSPENSION FOR (Pharmacy)	1	10.48			
13-Dec-2024	96372	Therapeutic, prophylactic, or diagnostic injection (Co.Pay)	1	9.00			
13-Dec-2024	96365	Intravenous infusion, for therapy, prophylaxis, or (Co.Pay)	1	46.80			
13-Dec-2024	0005-149902-1021	CLOFEN -(DICLOFENAC SODIUM : 75 MG/3ML) SOLUTION (Pharmacy)	1	6.50			
13-Dec-2024	2190-106618-1001	PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) S (Pharmacy)	1	8.40			
13-Dec-2024	0195-107704-0801	CEFTRIAXONE-TABUK IV (Pharmacy)	1	48.50			
13-Dec-2024	86140	C-reactive protein; (Lab)	1	12.60			
13-Dec-2024	85025	Blood count; complete (CBC), automated (Hgb, Hct, (Lab)	1	15.30			
				224.48			
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	13-Dec-2024	Humaira	J06.9	Acute upper respiratory infection, unspecified			Admitting Provider
Secondary	13-Dec-2024	Humaira	J30.9	Allergic rhinitis, unspecified			Admitting Provider
Secondary	13-Dec-2024	Humaira	R50.9	Fever, unspecified			Admitting Provider
Secondary	13-Dec-2024	Humaira	R05	Cough			Admitting Provider
Secondary	13-Dec-2024	Humaira	K29.00	Acute gastritis without bleeding			Admitting Provider
Secondary	13-Dec-2024	Humaira	J02.9	Acute pharyngitis, 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: Humaira				Patient/Guardian signature			
Tel/Fax: 0524244416							
Signature & Stamp:							
 							
Date: 13-12-2024				Date: 13-12-2024			
Claims should be submitted with supporting documents within 30 days from date of service or as per contract.							