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

PATIENT INFORMATION

Patient's Name (as on card)	KHOKAN SARKER BAKUL SARKER	○ Mr. ○ Mrs. ○ Ms.			
Card #	Policy No.	Birth Date :	04-Aug-1980 *dd mm yy*	**Sex:**	Male
784-1980-9693064-3					

INFORMATION

To be completed by Physician

Date of present symptoms:	13/12/2024 *dd mm yy*	Symptom(s) as described by Patient:

Complaint

co headache increase in blood pressure with out diagnosis of htn 11th dec. 2024

oe chest is clear no added sounds

restless

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
13-Dec-2024	9	Consultation GP **(General Consultation)**	1	**30.00**
13-Dec-2024	96372	Therapeutic, prophylactic, or diagnostic injection **(Co.Pay)**	1	**9.00**
13-Dec-2024	0005-149902-1021	CLOFEN -(DICLOFENAC SODIUM : 75 MG/3ML) SOLUTION **(Pharmacy)**	1	**6.50**
13-Dec-2024	80061	Lipid panel This panel must include the following: **(Lab)**	1	**44.10**
13-Dec-2024	80069	Renal function panel This panel must include the f **(Lab)**	1	**90.90**
				180.50

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	R03.0	Elevated blood-pressure reading, w/o diagnosis of htn			Admitting Provider
Secondary	13-Dec-2024	Humaira	R51.9	Headache, 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:

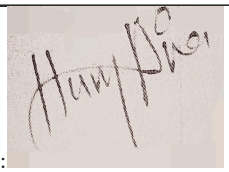
IN-PATIENT

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.	