

AL MADALLAH Form



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:	17-Dec-2024	Healthcare Provider:	CITICARE MEDICAL CENTER LLC
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PATIENT INFORMATION

Patient's Name (as on card)	Muhammad Hassan Altaf Ahmad	☐ Mr. ☐ Mrs. ☐ Ms.		
Card #	Policy No.	Birth Date :	29-Oct-1999	Sex: Male
784-1999-6403885-7			dd mm yy	

INFORMATION

To be completed by Physician

Date of present symptoms:	17/12/2024	Symptom(s) as described by Patient:
	dd mm yy	

Complaint

pc: cough

Pre-existing Condition(s) being treated for : Chronic Medications: Family History of any Illness	☐ No	☐ Yes	If Yes Specify
	☐ No	☐ Yes	
	☐ No	☐ Yes	

OBJECTIVE/ASSESSMENT

To be completed by Physician

Clinical Finding

Date	CPT Code	Treatment	Qty	Unit Price
17-Dec-2024	9	Consultation GP (General Consultation)	1	30.00
17-Dec-2024	94640	Pressurized or nonpressurized inhalation treatment (Co.Pay)	1	14.40
17-Dec-2024	0188-135906-2441	PULMICORT (Pharmacy)	1	10.48
				54.88

Cause	☐ Physical Illness	☐ Accident	☐ Maternity	☐ Preventive	☐ Psychiatric	☐ Dental	☐ Work Related
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☐ Other(s) Explain

Assessment/ Diagnosis	☐ Acute	☐ Chronic	☐ Confirmed	☐ Suspected
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Type	Date	Doctor	ICD Code	Diagnosis	Notes	year	Problem Role
Primary	17-Dec-2024	AHSAN HUSSAIN	R05	Cough			Admitting Provider
Secondary	17-Dec-2024	AHSAN HUSSAIN	J20.9	Acute bronchitis, unspecified			Admitting Provider

MEDICAL PLAN

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

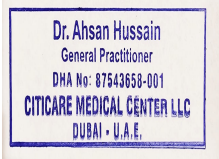
☐ Consultation	☐ Physiotherapy	☐ Laboratory	☐ Radiology/Other	☐ Pharmacy
			For Almadallah's Use only	
Pre-authorization Required for:			As per agreed tariff	
Full details of proposed treatment/Surgery/Medicine:			Approval Code:	

IN-PATIENT

Discharge summary, Itemized Invoices, Report, Results should be attached

Length of stay:	Provider: AL MADALLAH RN4	Cost:
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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: AHSAN HUSSAIN		Patient/Guardian signature	
Tel/Fax: 0521644729			
 Signature & Stamp:			
Date: 17-12-2024		Date: 17-12-2024	
Claims should be submitted with supporting documents within 30 days from date of service or as per contract.			