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

PATIENT INFORMATION

Patient's Name (as on card)	AJESH CHEKOTTU MACHINGAL	○ Mr. ○ Mrs. ○ Ms.			
Card #	Policy No.	Birth Date :	20-May-1984 (dd mm yy)	Sex:	Male
784-1984-5960817-4	P2420001915-5				

INFORMATION

To be completed by Physician

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

Complaint

PC: Low back pain

Duration: 4days.

There is no urinary symptoms and no GIT symptoms

No history of trauma.

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
17-Dec-2024	9	Consultation GP (General Consultation)	1	30.00
				30.00

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	17-Dec-2024	Enomen Goodluck	M54.5	Low back pain			Admitting Provider
Secondary	17-Dec-2024	Enomen Goodluck	R52	Pain, 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

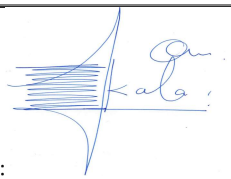
Length of stay:	**Provider: AL MADALLAH RN4**	**Cost:**

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: 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.