AL MADALLAH Form

almadallah Healthcare Management

Claim Form

استمـــارة 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

PATIENT INFORMATION

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

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

MEDICAL PLAN

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

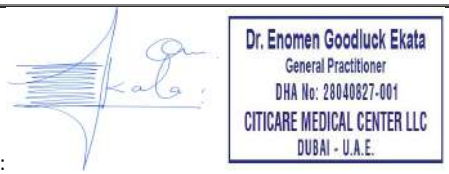
☐ **Consultation**	☐ **Physiotherapy**	☐ **Laboratory**	☐ **Radiology/Other**	☐ **Pharmacy**
			For Almadallah's Use only	
Pre-authorization Required for:			As per agreed tariff	
Full details of proposed treatment/Surgery/Medicine:			Approval Code:	

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.			