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

PATIENT INFORMATION

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

INFORMATION

To be completed by Physician

Date of present symptoms: 18/12/2024 *dd mm yy*	Symptom(s) as described by Patient:			
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
18-Dec-2024	9.01	Follow Up - Consultation GP **(General Consultation)**	1	**0.00**
18-Dec-2024	94640	Pressurized or nonpressurized inhalation treatment **(Co.Pay)**	1	**14.40**
18-Dec-2024	0188-135906-2441	PULMICORT **(Pharmacy)**	1	**10.48**
				24.88

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	18-Dec-2024	AHSAN HUSSAIN	R05	Cough			Admitting Provider
Secondary	18-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:**

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: 18-12-2024	Date: 18-12-2024
Claims should be submitted with supporting documents within 30 days from date of service or as per contract.	