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)	BALVIR KUMAR KUMAR	○ Mr. ○ Mrs. ○ Ms.				
Card #	Policy No.	Birth Date :	06-Dec-1978 *dd mm yy*	**Sex:**	Male	
784-1978-2703840-3						
INFORMATION		***To be completed by Physician***				
Date of present symptoms:	18/12/2024 *dd mm yy*	Symptom(s) as described by Patient:				

Complaint

co fever running nose dry cough

15th dec. 2024

oe chest is congested no added sounds

restless

smoker

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	Consultation GP **(General Consultation)**	1	**30.00**
18-Dec-2024	96365	Intravenous infusion, for therapy, prophylaxis, or **(Co.Pay)**	1	**46.80**
18-Dec-2024	96367	Intravenous infusion, for therapy, prophylaxis, or **(Co.Pay)**	1	**22.50**
18-Dec-2024	94640	Pressurized or nonpressurized inhalation treatment **(Co.Pay)**	1	**14.40**
18-Dec-2024	0188-135906-2441	PULMICORT-(BUDESONIDE : 0.5 MG/ML) SUSPENSION FOR **(Pharmacy)**	1	**10.48**
18-Dec-2024	96372	Therapeutic, prophylactic, or diagnostic injection **(Co.Pay)**	1	**9.00**
18-Dec-2024	0195-107704-0801	CEFTRIAXONE-TABUK IV **(Pharmacy)**	1	**48.50**
18-Dec-2024	0005-149902-1021	CLOFEN -(DICLOFENAC SODIUM : 75 MG/3ML) SOLUTION **(Pharmacy)**	1	**6.50**
18-Dec-2024	2190-106618-1001	PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) S **(Pharmacy)**	1	**8.40**
18-Dec-2024	86140	C-reactive protein; **(Lab)**	1	**12.60**
18-Dec-2024	85025	Blood count; complete (CBC), automated (Hgb, Hct, **(Lab)**	1	**15.30**
				224.48

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	Humaira	J06.9	Acute upper respiratory infection, unspecified			Admitting Provider
Secondary	18-Dec-2024	Humaira	J30.9	Allergic rhinitis, unspecified			Admitting Provider
Secondary	18-Dec-2024	Humaira	R50.9	Fever, unspecified			Admitting Provider
Secondary	18-Dec-2024	Humaira	R05	Cough			Admitting Provider
Secondary	18-Dec-2024	Humaira	K29.00	Acute gastritis without bleeding			Admitting Provider

MEDICAL PLAN

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

☐ **Consultation**	☐ **Physiotherapy**	☐ **Laboratory**	☐ **Radiology/Other**	☐ **Pharmacy**

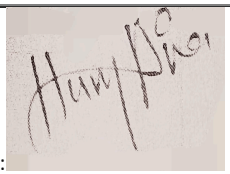
		For Almadallah's Use only
Pre-authorization Required for:		As per agreed tariff
Full details of proposed treatment/Surgery/Medicine:		Approval Code:

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:  Dr. Humaira Mumtaz General Practitioner DHA No: 54155530-002 CITICARE MEDICAL CENTER LLC DUBAI - U.A.E.			
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.			