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

PATIENT INFORMATION

Patient's Name (as on card)	Peris Wangari Kimari	○ Mr. ○ Mrs. ○ Ms.			
Card #	Policy No.	Birth Date :	20-May-1998 (dd mm yy)	Sex:	Female
784-1998-7427453-5					

INFORMATION

To be completed by Physician

Date of present symptoms:	19/12/2024 (dd mm yy)	Symptom(s) as described by Patient:

Complaint

the patient came complaining of prolonged uterine bleeding for more than 3 weeks

she is faint, pale and hypotensive

by abdominal ultrasound the uterus is enlarged with irregular outline suspecting the prescence of uterine mass

by transvaginal ultrasound the uterus shows fibroid 4.3 x 3.8 cm

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
19-Dec-2024	85025	Blood count; complete (CBC), automated (Hgb, Hct, **(Lab)**	1	**15.30**
19-Dec-2024	76817	Ultrasound, pregnant uterus, real time with image **(Radiology)**	1	**114.30**
19-Dec-2024	76830	Ultrasound, transvaginal **(Radiology)**	1	**140.40**
19-Dec-2024	10	Consultation Specialist **(General Consultation)**	1	**40.00**
				310.00

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	19-Dec-2024	MOHAMMED M HAMED	D64.9	Anemia, unspecified			Admitting Provider
Secondary	19-Dec-2024	MOHAMMED M HAMED	N93.9	Abnormal uterine and vaginal bleeding, unspecified			Admitting Provider

Type	Date	Doctor	ICD Code	Diagnosis	Notes	year	Problem Role
Secondary	19-Dec-2024	MOHAMMED M HAMED	D25.9	Leiomyoma of uterus, 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: MOHAMMED M HAMED		**Patient/Guardian signature**	
Tel/Fax: 0586108591			
Signature & Stamp:			
Date: 19-12-2024		Date: 19-12-2024	

Claims should be submitted with supporting documents within 30 days from date of service or as per contract.