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

co prolonged uterine bleeding for more than 3 weeks 29 nov. 2024

she is faint, pale and hypotensive

chest is clear no added sounds

restless

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	0102-152902-1001	LACTATED RINGERS INJECTION USP (Pharmacy)	1	5.00
19-Dec-2024	96360	Intravenous infusion, hydration; initial, 31 minut (Co.Pay)	1	32.40
19-Dec-2024	0005-149902-1021	CLOFEN (Pharmacy)	1	6.50
19-Dec-2024	96372	Therapeutic, prophylactic, or diagnostic injection (Co.Pay)	1	9.00
19-Dec-2024	9	Consultation GP (General Consultation)	1	30.00
				82.90

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	Humaira	D64.9	Anemia, unspecified			Admitting Provider

Type	Date	Doctor	ICD Code	Diagnosis	Notes	year	Problem Role
Secondary	19-Dec-2024	Humaira	N93.9	Abnormal uterine and vaginal bleeding, 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

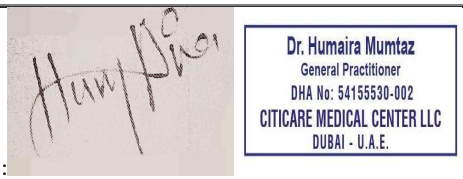
Length of stay:	**Provider: AL MADALLAH RN4**	**Cost:**

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: Humaira		**Patient/Guardian signature**	

Tel/Fax: 0524244416

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.