

AL MADALLAH Form



Claim Form

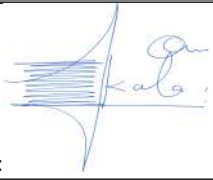
استمارة المطالبة

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:	19-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	Sex:	Male		
784-1999-6403885-7			dd mm yy				
INFORMATION							
To be completed by Physician							
Date of present symptoms:	19/12/2024	Symptom(s) as described by Patient:					
	dd mm yy						
Pre-existing Condition(s) being treated for : ☐ No ☐ Yes Chronic Medications: ☐ No ☐ Yes Family History of any Illness: ☐ No ☐ Yes							
If Yes Specify							
OBJECTIVE/ASSESSMENT							
To be completed by Physician							
Clinical Finding							
Date	CPT Code	Treatment	Qty	Unit Price			
19-Dec-2024	0188-135906-2441	PULMICORT (Pharmacy)	1	10.48			
19-Dec-2024	94640	Pressurized or nonpressurized inhalation treatment (Co.Pay)	1	14.40			
19-Dec-2024	9.01	Follow Up - Consultation GP (General Consultation)	1	0.00			
				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	19-Dec-2024	Enomen Goodluck	R05	Cough			Admitting Provider
Secondary	19-Dec-2024	Enomen Goodluck	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: Enomen Goodluck		Patient/Guardian signature	
Tel/Fax: 1234567			
 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.			

Dr. Enomen Goodluck Ekata
General Practitioner
DHA No: 28040827-001
CITICARE MEDICAL CENTER LLC
DUBAI - U.A.E.