

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)	rusiru rangajeewa		☐ Mr. ☐ Mrs. ☐ Ms.				
Card #	Policy No.	Birth Date :	24-Mar-1989	Sex:	Male		
784-1989-2063286-0			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						
Complaint							
PC: Fever, cough, headache, running nose and sorethroat and body pains. duration; 3days self medicating on panadol and cetirizine has history of elevated blood pressure but not on medications. not diabetic. does not smoke							
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	9	Consultation GP (General Consultation)	1	35.00			
				35.00			
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	Enomen Goodluck	J06.9	Acute upper respiratory infection, unspecified			Admitting Provider
Secondary	19-Dec-2024	Enomen Goodluck	J03.90	Acute tonsillitis, unspecified			Admitting Provider
Secondary	19-Dec-2024	Enomen Goodluck	R07.0	Pain in throat			Admitting Provider
Secondary	19-Dec-2024	Enomen Goodluck	R50.9	Fever, unspecified			Admitting Provider

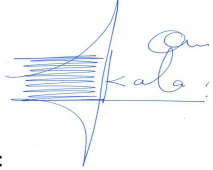
MEDICAL PLAN**Itemized Original Invoices & Applicable Prescriptions/Reports/Results must be enclosed to consider the claim**

☐ 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 RN3	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	
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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.	