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

PATIENT INFORMATION

Patient's Name (as on card)	MUHAMMAD ADNAN FAZAL REHMAN	○ Mr. ○ Mrs. ○ Ms.			
Card #	Policy No.	Birth Date :	01-Jan-1988	Sex:	Male
784-1987-0462425-7	IM237EA NLSB		dd mm yy		

INFORMATION

To be completed by Physician

Date of present symptoms:	20/12/2024 dd mm yy	Symptom(s) as described by Patient:

Complaint

co pain in the both legs 17th dec. 2024

oe

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
20-Dec-2024	9	Consultation GP (General Consultation)	1	30.00
				30.00

Cause	☐ Physical Illness	☐ Accident	☐ Maternity	☐ Preventive	☐ Psychiatric	☐ Dental	☐ Work Related
☐ Other(s) Explain							

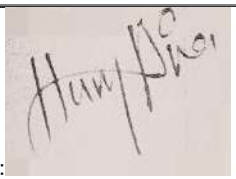
Assessment/ Diagnosis	☐ Acute	☐ Chronic	☐ Confirmed	☐ Suspected

Type	Date	Doctor	ICD Code	Diagnosis	Notes	year	Problem Role
Primary	20-Dec-2024	Humaira	M62.838	Other muscle spasm			Admitting Provider
Secondary	20-Dec-2024	Humaira	R52	Pain, 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: 20-12-2024		Date: 20-12-2024	
Claims should be submitted with supporting documents within 30 days from date of service or as per contract.			